Rural Hospitals:

The Politics of Institutional Change in the Health Sector

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Rebecca Orr

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Contents

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Abstract

This thesis uses conflicts over the role of rural hospitals in the Southern region as a means to explore how the health system created by the 1991 'Green and White Paper' works in practice. A combination of 'new institutionalist' and Alford's 'structural interests' approaches provide the conceptual tools. The thesis argues that the goals of the 1991 health reforms included an intention to redesign the institutional structure of the health system to reduce what was seen as the disproportionate power of local communities and providers, and privilege the fiscal interests of central government. But, as the thesis demonstrates, rural communities in alliance with providers, were sometimes able to overcome their lack of formal power and, however briefly, become significant actors in the health system. The case also points to the larger forces that made the Regional Health Authorities vulnerable to abolition in the Coalition Agreement of December 1996. The thesis also shows that the power of actors to influence the context and course of debates in the health system is not solely dependent on their formal institutional position, but is affected by informal relations and political pressures.

Chapter One: The Politics of Rural Hospitals

Introduction

There is nothing new about intense debate in the health sector over the role of rural hospitals. In recent years, however, these debates have become increasingly contentious as advances in medicine and surgery have undermined the need for the type of services provided by rural hospitals. As these technologies encourage the rationalisation and centralisation of high-tech and in-patient hospital services, rural communities fear their access to services will be reduced. This fear not only increases local attachment to rural hospitals, but reinforces the hospital's symbolic role within the community.

As the drive to rationalise and centralise services gathered momentum with the introduction of the health reforms in 1991, debates over rural hospitals escalated. Throughout the country, angry rural communities have entered into passionate debates with Regional Health Authorities (RHAs) and Crown Health Enterprises (CHEs) as they seek to defend their local hospitals. Repeatedly, rural communities have turned out in large numbers to 'save our hospital', and to protest against what they see as another factor in the gradual erosion of rural society.[1] Although RHA and CHE officials often view this attachment as more emotional than reasoned, rural communities argue these officials do not understand the needs of rural areas. The result is a "politics of power and conflict, of repeated trials of strength, with each side resisting what

[1]For more insight into this, see David Tranter, *Community or Chaos?: The Social Crisis in Rural New Zealand*, Unpublished monograph, New Zealand, 1995.

they see as the impositions of the other."[2] The issues, however, are not confined to rural hospitals, but raise broader and more serious questions about the health reforms. Ultimately, these questions have weakened the reforms' "fragile and uneven legitimacy," and contributed towards further restructuring of the system. [3]

The Controversy over Rural Hospitals

The Government's Perspective: Advancing Medical Technology and the Dilemma of Ensuring Access to High Quality Services.

At the heart of the debates over rural hospitals are the conflicting needs and perceptions of the key actors. For rural communities, their local hospital is not only a vital source of locally accessible health services but an integral part of the community itself. To central government, rural hospitals are inefficient, potentially unsafe, and historical legacies which have little value in a sector which emphasises health services rather than institutions. Behind these differences, however, lie much broader issues of how to maintain access for rural people to high technology services when the increasing sophistication of diagnostic, surgical and medical procedures favours their centralisation.

For central government, developing solutions to these dilemmas is not easy. On one hand, the increasing specialisation and sophistication of diagnostic, medical and surgical procedures offer dramatic improvements in the quality of care that can be offered to patients. However, it is impossible to provide all of these services in every locality because of

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[2]Geoff Fougere, "What Is the Core Business of Vote:Health?" in *Symposium on the Delivery of Health Services to Smaller Communities*, Wellington: National Advisory Committee on Core Health and Disability Support Services (NACCHDSS), 1995, p. 19.
[3]Ibid.

financial cost and the shortage of skilled staff. From the government's perspective, the solution is to centralise these services in a few "centres of excellence."[4] Although people would have to travel to access these services, the government argues that this system would allow the maximum benefit to be gained from them. Notwithstanding this, the government also foresees that the need to travel could be reduced by allowing providers throughout the country to access these services by "[plugging] in to the centres through telemedicine."[5] Centralising high technology services, however, has serious implications for rural hospitals. As Fougere identifies, it "sharpens the differences between large hospitals serving major population concentrations and small hospitals serving local populations."[6] This contrast does not reflect favourably on rural hospitals as it can make them appear inefficient, as well as posing greater risks to patients because of the smaller throughput of cases.[7]

However, the traditional role of both rural and urban hospitals as providers of health care is also being undermined by other changes in the practice of medicine. The increasing sophistication of medical technology and advances in surgical procedures have decreased the need for in-patient hospital beds, and reduced the length of time that patients need to remain in hospital. Developments in fibre optics, imaging technology and pharmaceuticals, for example, mean that many surgical operations are less invasive or able to be performed on a day stay basis.

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[4]Jenny Shipley, "Health Services into the Future", Speech by the Minister of Health to the New Zealand Medical Association Conference, 19 April 1994, p. 7.

[5]Jenny Shipley, *Advancing Health in New Zealand*, Wellington: Government Printer, 1996, p. 5.

[6]Fougere, "What Is the Core Business of Vote:Health?", op. cit., p. 19. For a discussion on the use of telemedicine and teleradiology in rural areas, see Chris Feltham, "The Role of Newer Technologies" in *Symposium on the Delivery of Health Services to Smaller Communities*, Wellington: NACCHDSS, 1995, pp. 90-102.

[7]For the impact of changes in surgery on smaller hospitals, see Richard Stewart and Kenneth Menzies, "Surgical Standards and Peripheral Surgical Units", *New Zealand Medical Journal*, vol. 101, no. 852, 1988, pp. 556-557.

Complementing this trend is the increasing number of medical procedures which are able to be performed by general practitioners, midwives and other non-hospital based providers in community settings.[8]

These trends not only coincide with, but also reinforce the development of community based care. With increased community based services providing this care, more conditions can be treated in the patient's own home, and earlier discharges from hospital are possible. Current government policy promotes the greater use of community based services, as from the state's perspective these services reduce costly hospital stays and eliminate the need to spend resources on maintaining hospital facilities. They also allow people to recover in their own home, which is often seen as more desirable than going to hospital.[9] For the government, the choice between increasing community based services or maintaining rural hospitals is clear: devoting resources to rural hospitals will deny communities the opportunity to use those same resources to increase their community based services. As the then Minister of Health, Jenny Shipley commented, "if communities wish to lock up resources in inefficient and sometimes unsafe hospitals then they must face up to the fact that this will be at the expense of other health services within their communities."[10]

The government recognises that changing the focus towards services "will challenge communities' parochial attitudes towards their local

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[8]Fougere, "What Is the Core Business of Vote:Health?", op. cit., p.19.

[9]For a discussion of the issues for rural communities and volunteer organisations of increasing community care, see Carole Searle, "What are the Consequences of Increasing Emphasis on Community Care?" in *Symposium on the Delivery of Health Services to Smaller Communities*, Wellington: NACCHDSS, 1995, pp. 130-136.

[10]Jenny Shipley, "Health Services of the Future", Speech by the Minister of Health to the Otago/Southland National Party Divisional Conference, 28 May 1994, p. 8.

hospitals."[11] The government clearly perceives that the public's view of hospitals is out of date, and still tends to defines access to health care through the presence of a hospital. This view was clearly seen in a speech by Jenny Shipley in early 1994, in which she stated:

> Successive ministers of health have struggled to counter quite outmoded attitudes to our public hospitals, attitudes which have been fostered by a small but very vocal group of professionals. The outmoded view has promoted the notion that hospitals are the 'be all and end all' of our health system. It has encouraged the public to believe that health services must be delivered in a traditional hospital setting - often referred to as the 'bricks and mortar' syndrome. Access to services is defined in terms of the presence or absence of a hospital.[12]

The government, however, is committed to shifting the focus away from hospitals as the main organisational unit of the health sector. As medicine gradually moves away from lengthy hospital stays, it is no longer desirable or practical for the government to commit resources to the maintenance of large numbers of hospitals.

The shift towards an emphasis on health services rather than institutions also allows government to reconfigure and rationalise resources more effectively. As medical technology continues to expand at incredible rates, it increases the medical profession's ability to treat illnesses, but places greater pressure on the government to balance a finite health budget with the seemingly limitless public demand for this new technology. Accordingly, this drives the government to seek to control not only the budget of the health sector, but the sector itself.[13] This

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[11] Ibid., p. 9.

[12] Jenny Shipley, "Health Services into the Future", Speech by the Minister of Health to the New Zealand Medical Association Conference, 19 April 1994, p. 5.

[13] Fougere, "What Is the Core Business of Vote:Health?", op. cit., p. 20. See also Geoff Fougere, "Restructuring the Health Sector: Bringing Politics Back In", Discussant paper for Health Services

control is aimed directly at making government better able to shift under-utilised or inappropriately located resources to balance these competing pressures. Unfortunately for rural communities, the government sees rural hospitals as representing a poor use of resources, which could be more advantageously devoted to primary care. Shifting resources from secondary to primary care, with its emphasis on prevention and early treatment, offers a way for government to ameliorate some of the public demand for new medical technology and achieve a greater return for the same resources.

The Perspective of Rural Communities: The Need for Local Services and the Symbolism of Hospitals

To rural communities, local hospitals are treasured as unique and precious community assets. Rural communities vigorously contest the government's claims that their hospitals are inefficient, inappropriate and anachronistic. Instead, they argue that a rural hospital is a vital source of locally accessible health services and an essential part of the community's infrastructure. However, rural communities value their hospitals not only for their role in delivering health services, but because they also perform a wide range of social and symbolic functions, considered by the community, although not the government, to be crucial. This symbolism exists on multiple levels, and as such is central to understanding the controversy over rural hospitals.

There is little doubt that rural communities value their hospitals as symbols of health and security. The perception of the hospital as a symbol of health is as much due to the historical role of the hospital as it

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Research Centre Conference 'Emerging Themes in New Zealand Health Care', Wellington, November 29 1994.

is to the ability of the hospital to allow individuals to remain in the community when they fall ill, and hence to be "properly healed."[14] To rural communities, 'health' is not just the provision of discrete services, but rather is about having an environment where sick people can be cared for and nurtured. This is particularly important for the elderly, who find larger urban hospitals intimidating, unfriendly, and difficult for family and friends to access. In comparison, being nursed in the local hospital offers more personal care, has easy access for friends and relatives, and allows individuals to remain within the supportive confines of their own community.

Equally importantly to rural communities is the sense of security provided by the hospital. The hospital is staffed for twenty-four hours, and consequently is seen as an important source of assistance when the general practitioner is not available. In times of emergency, rural people know they can always contact the hospital to get advice and reassurance from the staff on duty. This sense of security also extends to other health services in the locality. Rural communities consider that the presence of the hospital encourages the retention of other health services in the community, such as general practitioner and pharmaceutical services, as well as voluntary services like a local ambulance. Consequently, proposals to close rural hospitals incite fear in rural communities, which see the loss of the hospital as initiating a domino effect resulting in the loss of a much wider set of health services.

However, rural hospitals are not only symbols of health and security, but integral parts of the community's identity. This sense of identity can be traced back to the hospitals' origins. In the early twentieth century,

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[14]Interview with Darfield community member 22 January 1996.

many rural hospitals were built as a result of the efforts of their local communities. These communities not only extensively lobbied their local Hospital Board to obtain the hospital, but in many cases also raised money or donated land to facilitate its construction.[15] Once the hospital was built, it became an important symbol of pride and status. Particularly for new communities in a relatively young country, the hospital was perceived as an asset that, along with the local school and church, defined the identity of the community.

These efforts also fostered a strong sense of ownership on the part of rural communities towards their hospital, which in turn, have seen the hospital become a focal point for the community. Supporting the hospital through fundraising and voluntary work provides an important opportunity for social contact, particularly for people who live in isolated areas. The hospital, therefore, not only allows people to feel they are contributing to the community, but brings the community together in a common purpose.

One final factor that also accounts for the strong attachment of rural communities to their hospital is the economic recession and rural downturn of the mid to late 1980s. During that time, rural communities experienced a significant decrease in services as organisations like the Post Office, banks and transport companies centralised and rationalised services, and retail businesses closed with the fall in the spending power of rural families. The legacy of that experience, however, has been to make the hospital even more highly valued because it is perceived to be one of the few remaining services in

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[15]See W Norris, *Historical Notes: Country Hospitals and City Hospitals and Institutions other than Christchurch Hospital*, North Canterbury Hospital Board, 1942, and F O Bennett, *Hospitals On The Plains: Being An Historical Survey of the Origins of the Subsidiary Hospitals and Institutions of the North Canterbury Hospital Board*, Unpublished manuscript, 1975.

the community. Ultimately, threats to rural hospitals signify a loss that extends far beyond just the closure of an aging building.

The Perspective of the Regional Health Authorities (RHAs) and the Crown Health Enterprises (CHEs)

Situated between the opposing aims of the government and rural communities are the RHAs and CHEs. For the RHAs in particular, the issue of rural hospitals has been problematic and demanding. In general, the RHAs have found themselves at the centre of the conflicts over rural hospitals, because of their dual responsibilities to both central government and local communities. Under the reforms, the RHAs were to take account of government policy in their purchasing strategies, but were also required to work with individual communities to identify their health needs. Accordingly, as their purchasing decisions have aimed to increase community based services and not support institutions such as rural hospitals, the RHAs have found themselves subject to the anger of local communities. The RHAs, however, are less concerned with individual communities than with how to allocate health resources to gain the maximum benefit for all communities within the region. Unfortunately for the RHAs, achieving a more equitable allocation of scarce resources is extremely contentious because making gains in the areas of greatest need frequently demands removing resources from the 'over-provided' localities.[16] Any attempt to take resources away from communities to redress inequities has only drawn the RHAs into multiple political controversies that has seen them being criticised by communities and central government alike.

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[16]See, Southern Regional Health Authority, *1995/96 Draft Purchase Plan,* Dunedin: Southern Regional Health Authority, 1995, and Southern Regional Health Authority, *Planning For The South: Access To Health and Disability Services in The Southern Region,* Dunedin: Southern Regional Health Authority, 1994.

CHEs are drawn into these issues because as the owner of the hospitals, it is in part up to them to decide if services will continue to be delivered from those locations. For the CHEs to provide the services, however, they must receive a price from the RHA that will cover the costs of the service, or subsidise the service themselves. As the RHAs seek to extract the lowest price from providers, this often creates a financial shortfall which brings the RHAs and CHEs into conflict. As these disputes remain unresolved, this inevitably draws central government in to mediate a resolution. CHEs are also required to make a return for their shareholding Ministers, and this was intended to allow them to exit from unprofitable services. Accordingly, CHEs have strong incentives to close rural hospitals, as these services struggle to break even. However, some CHEs have also fostered close relationships with many rural communities, and are asked by those communities not to withdraw from their hospital. As a result, the institutional positioning of the RHAs and CHEs sees them enmeshed in the battles between central government and local communities, where each side attempts to use the RHAs and CHEs to further its own objectives.

Institutional Reform of the Health Sector and Debates over Rural Hospitals

Controversy over rural hospitals is not new in the health sector, as rural communities have a history of opposing repeated attempts by Hospital Boards and Area Health Boards to close rural hospitals as a means of reducing expenditure in times of fiscal constraint.[17] These debates are more than just disputes over specific facilities: they represent much

[17]For a recent example, see Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review (Akaroa, Darfield, Ellesmere, Lincoln, Rangiora, Waikari)*, Christchurch: Canterbury Area Health Board, 1991.

deeper conflicts over power and control of resources that are endemic to health sectors throughout the world. Crucially, these controversies are shaped by the institutional settings in which they occur. These settings regulate the actions of the contending parties, structure their goals and strategies for achieving those goals, and critically, privilege some actors while disadvantaging others.[18] Changes in such institutional settings can therefore be immediately consequential for the constitution of actors involved in the controversies, and for their degree of control over events.

The implications of alterations to institutional structures are particularly relevant to New Zealand, because in the last five years, the institutional configuration of the health system has been the subject of radical change.[19] In 1991, the National government abolished the existing Area Health Boards and placed responsibility for the purchase and provision of health services with the new RHAs and CHEs. This was in an attempt to introduce a 'managed market' into the health sector, where it was hoped competition between providers would drive innovation into the sector, and facilitate a more efficient allocation of health resources.

This institutional reform was aimed at increasing the relative power of central government to realise its aims vis a vis RHAs, CHEs and provider organisations and local communities. Specifically, the reformers argued that the then current institutional structure allowed providers and local communities too much power to allocate resources to meet their own specific needs and wants. In the case of the rural hospitals in Canterbury

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[18]See, for example, "Historical Institutionalism in Comparative Politics" in Sven Steinmo, Kathleen Thelen and Frank Longstreth (eds), *Structuring Politics*, New York: Cambridge University Press, 1992, pp. 1-32.

[19]See Simon Upton, *Your Health and the Public Health*, Wellington: Government Print, 1991.

considered here, the Area Health Board system allowed individual representatives and small coalitions of representatives from rural areas a high degree of influence over the Board's decisions. As the elected nature of these Boards also created opportunities for communities to use public opposition as a means of blocking unpopular proposals, rural communities were often able to defend their hospitals from attempts at closure.

The reformers contended the Area Health Board system 'privileged' these communities with the result that inappropriate and inefficient uses of resources were perpetuated. Consequently, this thesis argues that among the objectives of the reformers was the weakening of local communities' control over decisions concerning the allocation of resources. The reformers hoped to undercut communities' political influence by abolishing their directly elected representation on the regional health boards. Instead, the boards of the new RHAs and CHEs would be directly appointed by central government, and RHAs would be required only to 'consult' with local communities. This move would insulate the RHAs from community 'capture', and hence position them to make difficult rationing decisions in the sector.[20] It has therefore been the central focus of this thesis to examine how successfully the new institutional structure has been able to fulfil the original intentions of the reformers. This thesis has also sought to examine how informal relations and political pressures can influence the formal institutional power of different actors in the health sector so that the actors' true degree of power to control allocation decisions and other actors is either undermined or increased.

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[20]Fougere, "What Is the Core Business of Vote:Health?", op. cit., p. 21.

Methodology

The collection and analysis of data for this thesis has been an evolving process. As the focus of the research was refined, and more was understood about the topic at large, new research questions and issues emerged. Inevitably this involved some reconsideration of how the research was conducted. For example, an initial focus on the Canterbury region and on the cases of three hospitals within it was replaced by a focus that was at once wider and narrower. The focus expanded to include the whole of the SRHA's region, and specifically Otago and Southland as well as Canterbury. Yet the research also narrowed to concentrate on one particular hospital in Canterbury, Darfield, where there had been a co-ordinated community response to the latest threat to the hospital. Darfield has provided a key site for gathering detailed information about the relationship between local communities, RHAs, CHEs and central government. In addition to this, the thesis examines the cases of similar hospitals in Otago, as well as events at provincial hospitals such as Ashburton. Multiple research strategies were used to compile these accounts. These included unstructured interviews with key informants; analysis of documents produced by the government, the SRHA and Canterbury Health; analysis of other relevant documents such as community submissions, minutes of community meetings, and local newspaper articles; and the use of direct observation.[21]

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[21]This use of multiple research strategies represents a version of triangulation: the process of bringing different kinds of data to bear on a particular social phenomenon. For more detail, see among others, Norman Denzin, *The Research Act: A Theoretical Introduction to Sociological Methods*, 2nd ed., New York: McGraw-Hill, 1978, and Valerie Janesick, "The Dance of Qualitative Research Design", in Norman Denzin and Yvonna Lincoln (eds), *Handbook of Qualitative Research*, Thousand Oaks: Sage, 1994, pp. 209-219.

Selection of Data Sites

Following a brief overview of the literature on rural hospitals, it was initially decided to conduct a comparative case study of three rural hospitals in Canterbury: Lincoln, Darfield and Ellesmere.[22] These hospitals were chosen firstly because they all fell outside of the SRHA's criteria for the purchase of in-patient hospital services, that is, they were located within sixty minutes of Christchurch, and hence the SRHA would not pay a premium to purchase their services.[23] In essence, this meant the SRHA had decided that in-patient services were not required in those locations, and unless Healthlink South or Canterbury Health were willing to continue with the services, the hospitals would most likely close, or be the subject of a community trust. In addition to this, these hospitals were also chosen because Lincoln Hospital was owned by Healthlink South, whereas Darfield and Ellesmere were owned by Canterbury Health. At the time, Healthlink South had initially agreed to continue funding services at Lincoln, whereas Canterbury Health was undecided. Accordingly, this presented the opportunity for this thesis to contrast the approaches of the two CHEs.

As the research progressed, and the issue of access to services became more prominent, it was decided to change the case studies by including Waikari Hospital and eliminating Lincoln and Ellesmere. The decision to leave out Lincoln was made because it did not share many of the key characteristics of the other rural hospitals. As a solely maternity hospital, it did not have the range of services of the other hospitals, and

[22]These hospitals differed in the mix of services each provided. Darfield provided a mix of general medical and maternity services, Ellesmere provided general medical, long stay elderly, and post natal maternity services, whereas Lincoln solely provided maternity services. However, these differences were seen to be less important than the fact they fell outside of the SRHA's criteria.

[23]This criteria was set out in the SRHA's planning document *Planning for the South* released in June 1994.

hence was not as intimately connected to its community. Ellesmere was excluded because its strong similarity with Darfield meant that it was not adding anything to the research that was not already being obtained from Darfield. The decision to replace these hospitals with Waikari was firstly due to the similarity of functions provided by Waikari and Darfield, but secondly, was because Waikari fell within the SRHA's criteria for the payment of a premium. This contrast seemed more appropriate to highlight the validity of the SRHA's access criteria, and to examine the implications of those criteria for two rural communities.

As the research continued, the focus narrowed to issues of power, and how the ability and means available to rural communities to influence decisions had been altered by the health reforms. As a result, the contrasting strategies of the CHEs in Canterbury where rural hospitals have been sustained, and Otago where they have been closed, became an important point to investigate. However, this change in focus meant the comparison with Waikari was no longer as worthwhile as it had initially appeared. Precisely because they fell within the SRHA's criteria for a premium, the Waikari community had had very little need to mobilise against the SRHA, whereas the Darfield community had been actively engaged in a consultation process with both the SRHA and Canterbury Health to determine the future of its hospital. It was therefore decided to focus detailed analysis of community action on a single case study where there had been a co-ordinated effort by a local community to preserve their hospital.

Data Collection

One of the principal methods of date collection was unstructured interviews with key informants.[24] Unstructured interviews were used because they were the best method of allowing the participants to relate their own experience and understanding of the situation. The interviews were organised around broad questions that related to key themes, and were designed to allow the participants to discuss what they perceived to be the pertinent issues.

As the research required that the perceptions and perspectives of all the key actors be obtained, an interview program was developed that consisted of five main groups of participants. These were SRHA and CHE staff, general practitioners and staff at the hospitals, community members, former Canterbury Area Health Board staff and finally, additional key informants such as the Minister of Health. The participants from the community were chosen on the recommendations of the local general practitioners, the principal nurses, and other community members. Those from the SRHA and Canterbury Health were chosen because they had played a particular role in the process, or because they could authoritatively comment on the role of their organisation in the case study.

Contact with the rural hospitals was initially made through attending the Rural General Practitioners Conference in early 1995. This facilitated introductions to a number of rural general practitioners, who

[24]For more detail on the process of interviewing, see for example, Raymond Gorden, *Interviewing: Strategies, Techniques and Tactics*, 3rd ed., Homewood Illinios: Dorsey Press, 1980; John Lofland and Lyn Lofland, *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis*, 2nd ed., Belmont, California: Wadsworth Incorporated, 1984, and Andrea Fontana and James Frey, "Interviewing: The Art of Science" in Norman Denzin and Yvonna Lincoln (eds), *Handbook of Qualitative Research*, Thousand Oaks: Sage, 1994, pp. 361-376.

in turn supplied the names of the principal nurses of the hospitals, as well as other community members who had a strong association with the hospital. These people then recommended the names of others within the community whom they thought would be helpful for the research. The participants from the community also gave the names of the ex Canterbury Area Health Board members who had played a crucial role with the hospitals.

Contact with the Southern Regional Health Authority was made through contacting Janice Donaldson, who was responsible for requests made by the public for information. Ms Donaldson willingly supplied the names of staff who were involved with the rural hospitals in Canterbury, as well as the staff in the Dunedin branch who had been involved with issues concerning rural hospitals. Letters were sent to all participants indicating the nature of the research, and outlining what the interview would be about. These were then followed up with telephone calls, which allowed the participants to ask further questions, and their permission to use interview material to be sought. Of all the people who were contacted for this research, only one declined to participate.

Group A: SRHA and Canterbury Health Staff

The first group of participants comprised Board members, general managers and staff of both the Southern Regional Health Authority and Canterbury Health. Within the SRHA, there were three broad subcategories of participants. Firstly, there were those staff who had worked directly with the Darfield community through the consultation process. These consisted of the SRHA's community liaison officers, as

well as the staff member most directly involved with the consultation group and the negotiations with Canterbury Health. The second category was those staff who had worked with the rural hospitals in Otago, had direct contact with the community and had worked closely with the fledgling community trusts. The third group consisted of those staff who were involved with the issues on a more general level. Rather than their specific knowledge of Darfield, these participants were chosen because they had particular areas of expertise that were relevant to the research. These included a Board member who could present the issues from the SRHA Board's perspective, but who also had experience in establishing and running a community trust, as well as staff involved with the specific policy sections of the SRHA.

Within Canterbury Health, three key informants were chosen. These were the Chief Executive Officer, the general manager of Ashburton and Community Health Services and the chairman of the Canterbury Health Board of Directors. Two of these were chosen because they had both regularly attended the community's sub-committee, but were also able to comment on the issues as Canterbury Health perceived them. The Board member was selected because he was able to comment on the Board's perspective, and also because he had been closely involved with the establishment of the CHEs, and the placement of the rural hospitals into the new organisations.

These interviews were all conducted at the place of work of these staff members, with the exception of two interviews which were held at the participant's private homes. In general, the interviews were very formal, and were focused on the research questions. This was particularly the case with the SRHA, where the heavy workload of the staff meant the

interviews needed to be conducted with little wastage of time. The interviews lasted between thirty minutes and ninety minutes. The interview questions for both the SRHA and Canterbury Health broadly followed a similar pattern. Where appropriate, each participant was asked about the sequence of events relating to Darfield's, or Otago's, interaction with the SRHA over the application of the new purchasing criteria, and about their own role in the process. Participants were also asked about their organisation's relationship to the other key actors such as the community and central government. In addition to this, many of the staff had also been employed with the Canterbury Area Health Board. As a result, it was often possible to discuss issues that extended beyond their current role, and in particular, the way that the issue of rural hospitals had been addressed under the Area Health Board system.

Group B: General Practitioners and Staff of the Hospitals

The second group of people interviewed comprised local health professionals. These included the principal nurses of Ellesmere, Darfield and Waikari Hospitals, and one existing and one past staff member from Darfield. The local general practitioners from Waikari, Ellesmere and Darfield, who also acted as the Medical Superintendents of the hospitals, were also interviewed.

These interviews were conducted either at the private homes of the participants or at the hospitals. When the interviews were conducted at the hospitals, the principal nurse would often offer a tour of the facility. This provided an excellent opportunity for informal conversations to be held with staff, patients and other community people visiting or working at the hospital. It also allowed for observations to be made of

the hospital, and these often revealed the depth of the community's support. For example, many items had donation plaques attached to them, from both individuals and local organisations. At Waikari Hospital, the kitchen staff maintained a record of donations of goods by the community. Interviews were less formal than with the SRHA and Canterbury Health staff, and lasted between one hour and two hours.

For this group of participants, the interviews were organised around specific questions which were designed to elicit their interpretation of the events concerning their hospital, as well as more factual data on the services provided by the hospital. Some broader questions were also asked that sought interviewees' perception of the role of the hospital in the community, and about responses to past threats to the hospital. As some participants had also been present under the Canterbury Area Health Board, they were asked how they felt the hospital's position had altered with the health reforms.

Group C: Community Members

Interviews with the community members can be divided into two broad categories: those with individuals who were members of the Sub Committee of the Selwyn-Waimakariri District Health Group, and those with individuals who were not members, but had an interest in the hospital.[25] In this group, one had a formal role, being President of the 'Friends of the Darfield Hospital,' while the other had no formal affiliation to the hospital or health organisations, but was identified as being interested in the hospital and health issues in the district. Not all

[25]The Sub Committee of the Selwyn Waimakariri District Health Group was a sub-committee of the Southern Regional Health Authority's consultation committee. It was established by the Darfield community to provide a means where the community, the SRHA and Canterbury Health could meet to discuss the issues concerning Darfield Hospital.

members of the sub-committee were interviewed, as constraints on time made this impossible. Rather, the chairperson was selected, and three others were chosen on the basis of their involvement with other groups such as the SRHA's consultation committee, and the Malvern Health and Community Welfare Trust.[26] From the Darfield community, the President of the Friends of the Hospital was chosen as she had an intimate knowledge of the role of the hospital in the community, and one additional community member was chosen, again on the recommendations of others.

All interviews with community members from Ellesmere, Darfield and Waikari were conducted in the participant's private home, except two which were held at the participant's place of work. On the whole, the interviews were conducted in a relaxed manner, and this was often aided by the sharing of a cup of tea or lunch. On some of these occasions, other relatives of the participants would also be able to offer additional comments on the hospital or on the perceptions and composition of the community. As with the medical staff, the interviews were organised around discovering the reasons for the community's support of the hospital, what past threats to the hospital had occurred and how they had been resisted, the effect on the community of the rural downturn, and the suitability of a community trust. With the members of the sub-committee, questions were also asked concerning the formation of the committee, and the consultation process that occurred with the SRHA and Canterbury Health. Two community members were also members of the SRHA's consultation committee, and they were asked for their perceptions of the consultation process.

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[26]This is a community trust that was established by the local community to operate the district nursing and home aid services in the Malvern area when the services were no longer going to be run by the local general practitioners.

Group D: Former Canterbury Area Health Board (CAHB) Staff

The fourth group of people interviewed consisted of previous employees of the Canterbury Area Health Board, all of whom had some experience of the issues surrounding rural hospitals. Of this group, two were chosen because they occupied key positions of the AHB and were the local elected representatives from their communities. Their importance to the rural hospitals was also reinforced by the community members and hospital staff who were interviewed. Another participant was chosen because she was the former assistant-medical-superintendent-in-chief, country hospitals, and had been closely involved with the Board's review of rural hospitals in 1991. Two staff were chosen because they had written reports on the rural hospitals in Canterbury, including the 1991 review; one was selected because of her involvement with the CAHB's consultation groups; while the final staff member had been involved with developing the CHE structure and placing the rural hospitals within that structure.

All but two of these interviews were conducted at the participant's place of work. The interviews were organised around the participants' individual areas of expertise. In general, they involved gaining a mix of data on the issues presented by rural hospitals to the CAHB, as well as the participant's perceptions of the processes by which those issues were addressed.

Group E: Additional Key Informants

The final group of people interviewed consists of those individuals who did not fit into any of the aforementioned categories. Hence, this group involved people who either played a specific role in the case of Darfield, or who had a specialist knowledge of rural health or the health reforms. This group consisted of an interview with the Hon Jenny Shipley, who was the Minister of Health during the period of this case study, as well as the local Member of Parliament for the Selwyn, then Rakaia electorate. It also included David Tranter, who has travelled New Zealand specifically looking at rural communities, and the issues concerning their schools and hospitals. Professor Laurence Malcolm was also interviewed on the health reforms, and the latest round of restructuring.

One key issue that was prevalent during some interviews was the sensitivity of information. Particularly with the SRHA and CHE staff and some community members, concern was expressed about who else would have access to the information they were imparting. This was overcome by reassuring the participants that their names would not be attributed to any of their comments if they so wished. All the interviews were taped, and were transcribed after the interview However, during some interviews, the participants would ask for the dictaphone to be turned off, when they wanted to talk about sensitive issues. This request was always honoured, as the research was occurring in an situation that was ongoing, and where the participants had to continue working with one another. Information that was given during these times was only used in the most general of terms, or was not used at all, out of respect to the wishes of the participants.

Altogether, approximately 45 formal interviews were conducted. In addition, these formal interviews were also supplemented by further informal discussions. These included follow-up telephone conversations when additional information was required, and meetings with people at conferences and other events. During the course of this research, a number of events took place which allowed this researcher to meet people involved with the issues of rural health both at the national and local level. These included the Symposium on the Delivery of Health Services to Smaller Communities organised by the National Advisory Committee on Core Health and Disability Support Services in May 1995, and the SRHA's release of its locality profiles in June 1996. At both of these functions, a variety of people were present who were all associated with rural health and rural hospitals, and this allowed for additional insights and data to be gained from different areas of the country.

The second major research strategy utilised by this thesis was the analysis of documents produced by central government, the SRHA, Canterbury Health, and the local community. These included a range of materials, including media releases, Ministerial speeches, published reports by the Ministry of Health and the SRHA, internal reports from Canterbury Health, minutes of the meetings from the sub-committee and the public meeting organised by the community, and a submission made to Canterbury Health by the Darfield community on the hospital. This contemporary material was supplemented by reports from the Canterbury Area Health Board, and archival material from the private collection of two former Board members. Notable amongst this material was the Canterbury Area Health Board's review of six of its rural hospitals in 1991. This review had extensively profiled these hospitals,

and was the starting point for understanding the issues raised by rural hospitals in a New Zealand context. This material was used to augment, support and cross check the data gained from the interviews. These documents were also supplemented by international publications on rural hospitals and rural hospital closure, showing that the issues in New Zealand are endemic to health systems elsewhere.[27]

Data Analysis

Analysis of the data from the interviews and relevant documents was performed according to the method outlined in Neuman's work on analysis of qualitative data.[28] The data was firstly organised into chronological order, and a sequence of key events was established. During the first open phase of coding, critical terms and themes were identified from the specific needs and priorities as expressed by each of the different actors. Once these general themes were identified, the second stage of axial coding involved reviewing these themes to identify the underlying causes and explanations for the behaviour of each of the

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[27]For examples of international literature on the closure of rural hospitals , see Simonetti Samuels, James Cunningham and Christina Choi, "The Impact of Hospital Closures on Travel Time to Hospitals", *Inquiry*, vol. 28, 1991, pp. 194-199; Marsha Lillie-Blanton, Suzanne Felt, Patrick Redmon, Steven Renn, Steve Machlin and Elizabeth Wennar, "Rural and Urban Hospital Closures, 1985-1988: Operating and Environmental Characteristics that Affect Risk", *Inquiry*, vol. 29, 1992, pp. 332-344; Jonathon Mayer, Elizabeth Kohlenberg, G. Sieferman and Roger Rosenblatt, "Patterns of Rural Hospital Closure in the United States", Social *Science and Medicine*, vol. 24, no. 4, pp. 327-334, 1987; Sara McLafferty, "The Geographical Restructuring of Urban Hospitals: Spatial Dimensions of Corporate Strategy", *Social Science and Medicine*, vol. 23, no. 10, 1986, pp. 1079-1086; R. M. Mullner, "Rural Hospital Survival: An Analysis of Facilities and Services Correlated With Risk of Closure", *Hospital and Health Services Administration*, vol. 35, no. 1, 1990, pp. 121-137; Andrew Bindman, Dennis Keane and Nicole Lurie, "A Public Hospital Closes", *Journal of the American Medical Association*, vol. 264, no. 22, 1990, pp. 2899-2904; Thomas Chapman, "Hospital Viability and Closures", *Journal of Health Care for the Poor and Underserved*, vol. 1, no. 1, 1990, pp. 96-102; Niccie McKay and John Coventry, "Access Implications of Rural Hospital Closures and Conversions", *Hospital and Health Services Administration*, vol. 40, no. 2, 1995, pp. 227-246; David Berry and John Seavey, "Assuring Access to Rural Health Services: The Case for Revitalising Small Rural Hospitals", Health Care Management Review, vol. 19, no. 2, 1994, pp. 32-42; Kyle Muss, Richard Ludtke and Brad Gibbens, "Community Perceptions of Rural Hospital Closure", *Journal of Community Health*, vol. 20, no. 1, 1995, pp. 65-73; Steven Fleming, Harold Williamson, and Lanis Hicks, "Rural Hospital Closures and Access to Services", *Hospital and Health Services Administration*, vol. 40, no. 2, 1995, pp. 247-262.

[28]W. Lawrence Neuman, *Social Research Methods: Qualitative and Qualitative Approaches*, 2nd ed., Boston: Allyn and Bacon, 1994.

actors. This review also sought to examine the interactions of the actors, the different strategies they employed, and where the key areas of divergence between the needs of each of the actors occurred. The final stage of selective coding comprised compiling evidence for the patterns and explanations that had been identified, and analysing in depth the different relationships between each of the actors.

Outline

The central aims of this study are twofold. First, it seeks to investigate why controversies over rural hospitals are so rancorous, arguing that at the heart of the debate is a deep conflict between the needs and perceptions of the central actors. Second, this study explores the implications of the institutional changes made by the health reforms for the course of these debates, explaining how the power of actors in the health system is affected by the intertwining of formal institutional position, informal relationships and political pressures.

Chapter Two explores the attachment of rural communities to their local hospitals in more depth, and shows how the institutional structure of the Area Health Board system allowed rural communities to resist attempts at closure of their hospitals. Chapter Three then outlines the new institutionalist literature and places the origins of the health reforms, and their aims in the context of Alford's theory on power relations between the different interests produced by modern health systems. Chapter Four then examines the implementation of the reforms, and how their ideological basis was sacrificed to the needs of political expediency. It shows how rural hospitals were placed into the new RHA and CHE structure, and how it was hoped that this new

institutional setting would allow the RHAs and CHEs to redistribute resources away from smaller hospitals. Finally, Chapter Five explores how the reformed health system altered the power relationships between RHAs, CHEs, central government and local communities. It focuses on accounting for why the outcomes were not as the reformers had anticipated or desired. Chapter Six concludes with a discussion on the latest restructuring, and what lessons policy makers can learn from these latest rounds of conflicts over rural hospitals.

Chapter Two: Rural Hospitals in Canterbury

Introduction

From the early twentieth century, rural communities in Canterbury have viewed their local hospitals as a critical element in the network of health services available in their localities. Since the hospitals' origins, however, this view has rarely been shared by urban health planners in the cities. As the utilisation of the hospitals has fluctuated, these planners have seen rural hospitals as inefficient and uneconomic. As a result, the history of rural hospitals in Canterbury is punctuated by repeated struggles between city administrators wishing to close them, and local communities not wanting to lose a valued community asset. In general, these struggles have been won by rural communities working in conjunction with small coalitions of Board members. The success of these groups, however, only contributed to the perception of the new National government in 1991 that the institutional structure of the health system was flawed. Area Health Boards clearly found it very difficult to make unpopular rationing decisions such as the shifting of resources away from rural hospitals, and ultimately this led to the Boards' demise in the redesign of the health system. This chapter analyses the reasons behind rural communities' attachment to their hospitals, and argues that their devotion is not just emotional or parochial, but rather is support given to an institution that has from its inception been an important symbol for the community. The ways in which the institutional structure of the Hospital and Area Health Boards allowed the communities' effective defence of the hospitals is also examined.

Establishment in the Community: 1915-1960

The origins of the rural hospitals in Canterbury can be traced back to the early 1920s. At that time, there was a national campaign to reduce New Zealand's high rate of maternal mortality and improve the standard of obstetric care.[1] These efforts at reform embraced a number of measures including the provision of ante-natal care and the introduction of aseptic procedures in hospitals, but crucially, they encouraged the building of small, public maternity hospitals. In Canterbury, this saw hospitals opened in Oxford, Waikari, Amuri, Cheviot, Ellesmere, Rangiora, Lincoln and Darfield by 1927. Although these hospitals were primarily intended to be maternity homes, many were also designed to accommodate some general patients, and were built with small operating theatres to perform minor surgery.[2]

In many cases, the hospitals were established largely as a result of the efforts of the local county councils. In general, when a council desired a hospital, it would send a deputation to wait on the Hospital Board. This deputation would argue the community's case and would frequently bolster its application by offering to subsidise the construction costs through money or donations of land.[3] Hospital Board approval for new hospitals was virtually assured, because half of the Board's members came from rural areas.[4] Moreover, once the Hospital Board had granted

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[1]New Zealand's maternal mortality rate had been steadily rising from a low point of 3.58 per 1,000 live births to 6.48 in 1920, and was considered to be among the worst in the world. The motivation to address the problem, however, did not come until a few years later when the deaths of five women at the Kelvin Hospital prompted the government to support the Health Department's efforts at reform. For more detail on this, and on the cultural, racial and political factors underlying the government's efforts to improve the maternal mortality rate, see Philippa Lyn Mein Smith, *The State and Maternity Care in New Zealand 1920-1935*, Unpublished MA Thesis, University of Canterbury, 1982.

[2]Norris, *Historical Notes*, op. cit.

[3]F O Bennett, *Hospitals On The Plains*, op. cit., p. 75.

[4]Ibid, pp. 75-76.

one district's application for a hospital, it was extremely difficult to refuse new applications.[5]

Although individual counties could argue a need for a maternity hospital, their desire for a hospital was also fuelled by the consideration that other districts were also getting maternity hospitals.[6] For small, isolated communities in a relatively young country, having a local hospital was a status symbol, an important sign of civilisation which showed that the community was established and thriving. The prestige associated with having a hospital led to their proliferation, as they became increasingly desirable to other districts in the area. The result was that too many hospitals were built for the needs of the region, and this over-supply has contributed to the consistent problems of utilisation and funding experienced by the hospitals.[7]

Even when the hospitals were opened, they were used far less than anticipated. Bennett argues that this was because "as soon as the hospital was erected to fulfil a public need, the need ceased to exist."[8] For some patients, this was due to an individual preference to remain at home or to travel to Christchurch rather than use the local hospital. In other instances it was because people had little confidence in either the doctor or the nursing staff. In other cases, "it was a mistrust of something new

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[5]Ibid.

[6]Ibid, p. 99.

[7]Once the hospital was built, the Hospital Board appointed the local doctor to control the hospital, while nursing and domestic staff were supplied from Christchurch Hospital. In reality, the Hospital Board had little choice in appointing the doctor to control the hospital. This was because even if the Board did not approve of the doctor, it was unable to take any action because the doctor was in the district by right of having purchased a private practice. Although the hospitals were funded through a mixture of Hospital Board subsidies and local rates, historical records differ on whether the doctor was able to charge patients. Bennet claims the doctor was not allowed to charge fees to hospital patients, but was paid a small salary from the Hospital Board as compensation. Norris, however, states the doctor was permitted to make his own arrangements with the patients who could afford to pay his charges, and was paid a salary from the Hospital Board to treat those patients unable to pay, see Bennett, *Hospitals On The Plains*, op. cit., and Norris, *Historical Notes*, op. cit.

[8]Bennett, *Hospitals On The Plains* op. cit., p. 76.

or an obstinate preference for something old."[9] The consequence of this "was that the big white building was, in the beginning, something like a big white elephant."[10] As time passed, however, the local prejudice faded and the hospitals became central to the community.

Despite this initial low utilisation, the hospitals did provide a valuable and essential service to their communities, and as such, became powerful symbols of health. The hospitals were all built at a time when medicine was less sophisticated, the modern drugs of today did not exist, and ambulance services were limited. Transport, roading and communication presented much greater barriers to receiving health care, especially in times of emergency. Patient survival, particularly after childbirth, was also much more uncertain. So when a doctor could be many hours away, the hospitals were seen as providing locally accessible medical attention, offering security and reassurance to local people in times of need. Some hospitals also performed minor surgery and provided beds for patients to convalesce after illness or accidents, and were valued because they allowed patients to remain in the community, where they could be near to family and friends.

These origins of the hospitals are significant because they shed light on why rural communities feel such a strong attachment to them. From the beginning, the hospitals were an important source of security, pride and community identity, which helped to fulfil the needs of the people living and working in those small and isolated communities. The community initiative which resulted in the hospitals being built also meant that from the beginning, the community was entwined with the

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[9] Ibid, p. 76.
[10] Ibid.

establishment and maintenance of the hospitals. This forged a very strong sense among rural communities that the hospital was 'theirs', and this feeling still exists today.

The first significant threat to all the country hospitals came with the onset of the Depression. At that time, all the country hospitals were in danger of being seen as luxuries, and the government strongly endorsed their closure.[11] For rural communities, the possibility of losing their local hospital initiated a vigorous defence of them. In Waikari, for example, the Department of Health issued a report that recommended either Waikari or Amuri Hospital be closed, as they provided similar services, and were located within thirty minutes of each other, with a good road connecting them. However, this suggestion was vigorously opposed by the Waipara County Council, the general practitioner and the local Plunket Society who all strongly protested to the Hospital Board against any attempt by the Department to close either hospital.[12] These efforts were successful, and neither hospital closed.

The hospitals were again threatened at the outbreak of World War II, as the Department of Health saw their closure as a means of economising on nurses, but community efforts prevented any closures from occurring.[13] These early threats and the successful community responses to them are very significant because they formed an important precedent within rural communities. Through organising a co-ordinated and vocal response to proposals to close their hospitals, rural communities learnt they could generate political pressure which would stave off these proposals. These defences also formed a proud tradition which became

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[11]Ibid, p. 77.
[12]Norris, *Historical Notes,* op. cit.
[13]Bennett, *Hospitals On The Plains* op cit, p. 77.

part of the hospital and the community's history. In turn, this pride has been passed on to future generations and continues to shape the way that these communities respond when their hospitals are threatened.

During the 1950s, the rural hospitals in Canterbury were at their highest levels of utilisation, and they also returned to being solely maternity hospitals. Helped by the post World War II baby boom, the hospitals were nearly always full, but several outbreaks of the H-Bug (staphylococcus aureus) resulted in the implementation of Obstetric Regulations that forbade the hospitals from caring for both maternity and general patients.[14] Although this was not immediately significant, later decreases in the birth rate meant that these Regulations would severely undermine the existence of the hospitals.

In essence, this early period represented the heyday of the hospitals. They were well utilised, and there was very little argument that they were providing an essential service. They enjoyed a reasonably secure position, and community efforts were easily able to oppose the few threats that they did experience. In a time of greater financial prosperity, they were allowed to be symbols of pride, and communities were able to exercise a far greater influence over them. Hence, the period to 1960 offered years of relative stability in contrast to the turbulence the next three decades would bring.

[14]Interview, former Canterbury Area Health Board staff member, 9 July 1996.

Hospital Utilisation and the Rural Downturn: 1960-1988

Over the next thirty years, the rural hospitals experienced a series of increasingly stronger threats which developed as a result of wider changes within society, and more specifically within the practice of obstetrics. In the early part of this period, as the prosperity of the early 1960s declined, the hospitals remained reasonably secure. In part, this was aided by the strength of the farming sector which gave rural areas considerable political power. Rural members on the Hospital Board were able to argue that rural hospital services should be retained because rural areas made such a strong contribution to the national economy, and therefore, were equally entitled to services as the urban centres. However, with the onset of the 1980s, and a further decline in the usage of the hospitals, the ever burgeoning financial pressure on health spending meant that this previous security began to diminish rapidly. Communities were able to overcome successive crises by lobbying Hospital Board members, and through the actions of key rural members of the Hospital Board. From these repeated threats, rural communities developed a pattern of actions and responses that was generally effective until the health reforms of 1991.

From 1960, rural hospitals began to be surrounded by an increasing climate of uncertainty. In that year, the North Canterbury Hospital Board considered recommendations by its Institutions Committee to close country hospitals for financial reasons. It was proposed to shut Amuri Hospital temporarily and retain Waikari, and a year later this went ahead. In spite of strong community opposition to the closure, the Amuri hospital did not re-open, and was permanently closed in 1967.[15]

[15]Interview, former Canterbury Area Health Board member, 16 February 1996.

Three other hospitals, Lyttelton, Cheviot and Kaiapoi, were also closed during this time.[16] Significant improvements in communication, roading, and transportation had reduced the traditional isolation of many rural people, but nonetheless, these closures fostered an atmosphere of uncertainty and apprehension about the remaining hospitals. This sense of anxiety has lingered in rural communities, and has contributed to the feelings of beleaguerment, and the sense that "we've been through this all before" that exists in rural communities today.

From the late 1960s, the number of deliveries performed at the country hospitals began to decline significantly. This impacted on the hospitals severely, because it dramatically reduced their utilisation, and hence struck at the core of their business. Initially, it was the introduction and widespread use of the female contraceptive pill that accounted for a large drop in the birth rate. This fall was embedded in changing social patterns which resulted in women having fewer children and delaying their childbearing until later in life. Although these factors also resulted in a national decline in the birth rate, it was particularly hard for the rural hospitals as they were solely maternity facilities, and did not have a range of services to supplement their utilisation.

By the mid 1970s, the hospitals were starting to be harmed by changes in the discipline of obstetrics which began to favour the use of base hospitals over smaller, rural facilities. At this time, trends in obstetrics began to encourage greater medical intervention in pregnancy and childbirth. Hence women were encouraged to have their pregnancies regularly

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[16]John Holmes, *A Report on the Use of Hospital Services by the Rural Population of Canterbury*, Community Health Care Services, North Canterbury Hospital Board, May 1986.

monitored, and to deliver in major centres with the advanced facilities of a city hospital. This manifested itself most notably with first births, as these have the greatest potential for unforeseen complications, and heavy emphasis was placed on all first deliveries being conducted at a base hospital. At the same time Canterbury had more doctors who had trained since the early 1970s, and expected that women would birth in the larger centres.[17] The result was that rural hospitals lost a lot of business. As one rural GP commented:

All of a sudden instead of obstetrics being something that GPs did . . . we were being trained to refer more, and get more care when things started going wrong. . . . When I came out here, I made a decision I wasn't going to deliver first babies . . . but that was indicative of the sort of attitudes that were starting to come into obstetric practice at that time, which meant not as many deliveries would be done in these sort of places.[18]

Not only did this change diminish the utilisation of the hospital, it also seriously damaged the attitudes that both the local general practitioners and the women of the community held towards the hospital. Many clinicians now considered it to be potentially dangerous to birth in a smaller centre, and gradually these perceptions were also adopted by the women themselves. As one former staff member recalled:

Up until the late seventies, everyone was born at Darfield if the mother chose. . . .In the late seventies and early eighties . . . there was a huge push towards state hospitals for birthing . . . [and] I perceived women were being shoved towards the city for childbirth because it was safer. And therefore all of the community or country hospitals were losing business because it was very unfashionable and very unsafe to birth in a community hospital. So this thriving little hospital of the fifties, where twins were born and all sorts of

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[17]Ibid., p.6.

[18]Interview, rural General Practitioner, 3 December 1995.

things happened, slowly and surely it was run down to the point where there was very low occupancy.[19]

Clinical safety has always been a major issue for rural hospitals,[20] and these concerns over the isolation of the hospitals meant that policies were developed which indicated that hospitals should not deliver first babies, but should instead deliver only those women who had previously had normal deliveries. Again, this severely reduced the potential market of the hospitals. As a former Canterbury Area Health Board member commented:

. . . especially for the first baby when they don't really know what's going to happen . . . if things start to go wrong, to get them into an ambulance and take them to Christchurch, that's when you can get a damaged child, and the average family size is two children, and you want two healthy children, you don't want handicapped children, and that was the argument really, to say no first babies and then only ones that had had no problems with their first ones. But that's cutting out a big percentage of your births in your area.[21]

The position of the hospitals was also affected in the 1970s by the rural doctor crisis.[22] At this time there was a severe shortage of doctors, and this was particularly acute in rural areas, chiefly because of the high demands placed on doctors by a solo rural practice.[23] The implications of

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[19]Interview, former Darfield Hospital staff member, 26 April 1996.

[20]See, for example, Roger Rosenblatt, Judith Reinken and Phil Shoemack, "Is Obstetrics Safe in Small Hospitals?", *The Lancet*, vol. 2, 1985, pp. 429-431.

[21]Interview, former Canterbury Area Health Board member, 2 May 1996.

[22]For more detail, see the Medical Association of New Zealand, *Central General Practitioners Committee Final Report on Rural Practice*, Wellington, February 1969, and "Rural Doctor Crisis: A Matter of Life and Death", *Straight Furrow*, 20 October 1971, pp. 4-5. For further information on the distribution of doctors in New Zealand since the early 1970s, see J R Barnett, "Where Have All the Doctors Gone? Changes in the Geographic Distribution of General Practitioners in New Zealand Since 1975. 1: Regional and Urban-Rural Differences", *New Zealand Medical Journal*, vol. 104, pp. 314-316.

[23]For more detail on this, see among others, J. Fountain, "The Needs of the Rural Doctor", Paper presented at the Twenty Eighth Lincoln College Farmer's Conference, Lincoln College, 8-10 May 1978; Martin London, "Rural General Practice in New Zealand: Pernicious Goal or Prestigious Goal?", *The New Zealand Family Physician*, Summer 1991, pp. 19-21; Sanya Baker, "Patients Not Safe When Rural GPs Are Isolated", *New Zealand Doctor*, 15 September 1994, p. 27.

this for rural hospitals were twofold. First, it meant that doctors saw rural hospitals as an incentive to live and work in a rural area. As a former Canterbury Area Health Board staff member pointed out:

. . . in the 1970s and early 80s, when getting doctors for rural communities was dreadfully difficult . . . hospitals were seen as a carrot. If you could say there was a hospital there, they could feel much more supported, and it's much more interesting to have a hospital to admit your own patients to.[24]

However, the second implication of this attitude was to create a very strong belief in rural communities that a local hospital was important in order to retain a general practitioner. Rural general practitioners and rural hospitals have a very interdependent relationship, where the hospital acts as a source of professional support to the general practitioner, and can ameliorate some of the hardships of solo rural practice. During the time of the rural doctor crisis, especially in North Canterbury, many of the practices remained vacant for quite some time, or else general practitioners who did come stayed only briefly. Hence this has created a fear amongst many rural communities that if the hospital is closed, then there is a strong possibility the local doctor will no longer wish to stay in the district, as one community member commented:

. . . my father was Chairman of a county, and during his time as Chairman, their hospital was closed. And the trouble that they then had to get a GP into the area because it was a slightly isolated area, and there weren't any GPs who wanted to go and work up there. And the thought to me of closing the hospital would bring back the same scenario that if we lost our hospital we would lose the incentive for GPs to be in the district. It was really quite concerning.[25]

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[24]Interview, former Canterbury Area Health Board staff member, 9 July 1996.
[25]Interview, Darfield community member, 31 January 1996.

This fear is still very prevalent today, with many community members mentioning it in my interviews with them.

By the late 1970s and early 1980s, the Hospital Board was once more under pressure to justify the existence of rural hospitals, given their low utilisation. As had happened in the past, the possibility of closure was raised, again because rural hospitals were not seen as being cost effective for the services they provided:

. . . they weren't being used enough as maternity to justify spending that sort of money on them.[26]

To address this issue, the Hospital Board sought to reintroduce general patients back into the hospitals. This became known as the policy of greater utilisation, and was explicitly targeted at expanding the role of the rural hospitals. As a former member of the Hospital Board explained:

. . . if you had a hospital there, which was quite costly to run, using a lot of staff resources . . . it was uneconomic to attempt to run it unless you got the greatest utilisation you could. It's no good having it half empty all the time.[27]

However, for general patients to be once again present in rural hospitals, the Obstetric Regulations that existed had to be changed, as these prevented general patients and maternity patients from being cared for in the same facility unless there was a complete separation of the two. Sources vary on the exact details of the process by which this problem was overcome, but the predominant account states that the then Medical Superintendent-in-Chief wrote to the Department of Health seeking a

[26]Interview, Former Canterbury Area Health Board member, 2 May 1996.
[27]Interview, Former Canterbury Area Health Board member, 16 February 1996.

specific departure from the Obstetric Regulations for the rural hospitals. Although a variety of reasons was given for this request, the central reason was the poor cost-effectiveness of the rural hospitals because of their low occupancy rates. To aid in its request, the North Canterbury Hospital Board invited the Deputy Director-General and the Assistant Director, Hospitals Division, from the Health Department to visit selected rural hospitals in July 1980.[28]

After this visit, correspondence from the time appears to indicate that the Department was willling to sanction general patients being admitted into some of the hospitals, although official approval was never granted. As a local general practitioner commented:

. . .after [the visit], although the regulations weren't changed, we started using it for general patients. Which strictly speaking we weren't supposed to, although it was sort of indicated a blind eye would be turned if we kept the general patients at one end and the obstetric patients at the other.[29]

Although the Hospital Board tried repeatedly for official approval, the Department would not push for a change in the legislation, as it was not willing to accept responsibility for the actions of the Hospital Board.[30]

However, the implementation of this policy by the Board is very significant because if it had not been for the presence of key individuals on the Board who were able to initiate and support this policy, then it is possible that a different outcome would have occurred. Yet these individuals were able to be as effective as they were only because of the institutional structure within which they operated. Essentially, because

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[28]Interview, former Canterbury Area Health Board staff member, 9 July 1996.
[29]Interview, rural General Practitioner, 3 December 1995.
[30]Interview, former Canterbury Area Health Board staff member, 9 July 1996.

the Hospital Board was constituted wholly of popularly elected members, this closely linked them with the people they represented, and it meant the Board members were predisposed to making decisions that were consistent with community demands. In the case of the rural hospitals in Canterbury, and particularly for Darfield and Waikari, they were represented by Tom Grigg, who was the Chairman of the Board, and by Mrs June Gardiner, who would later become the Deputy Chairman. Both of these individuals were extremely committed to the hospitals in their areas, occupied powerful positions within the Board hierarchy, and were generally recognised as being highly politically skilled. So despite being outnumbered on the Board, these members could marshal arguments for why the hospitals should be retained, and could then successfully lobby the other Board members. Their arguments would often focus on the need for the services the hospitals were providing, the good they were doing in their communities, and the extra cost that would be involved to provide the services in an alternative way if the hospitals were to shut. Hence, as Tom Grigg stated:

. . .between Mrs Gardiner and myself, we convinced the other Board members and the administration that there really wasn't a case.[31]

The presence of key individuals on the Board who were able to defend the hospitals successfully had a powerful impact on the expectations of communities concerning the role of health administrators. The existence of a popularly elected Board meant communities had a very visible representative to whom they could express their opinions and needs, and because the Board consisted of elected members, it was seen to

[31] Interview, Former Canterbury Area Health Board member, Tom Grigg, 2 May 1996.

be very accountable to the community. As a former Canterbury Area Health Board member commented:

. . .it was the elected Boards who were speaking for their communities, and justifying for their communities that won the day.[32]

With the presence of powerfully positioned rural members on the Board, community lobbying was very successful in resisting moves by the Board to reduce the services or close rural hospitals. This meant that communities had quite a strong sense of control.

When the rural hospitals in Canterbury began to care for both maternity and general patients in the early 1980s, it improved their utilisation, but the effectiveness of the policy was weakened by the development of specialist services in the major hospitals. As medical technology improved, this reinforced the trend for people to be referred to specialists in the city, and away from being managed by their GP in the local hospital.

Not only did this change the role of the general practitioner to a referrer rather than a patient manager, it also created perceptions in rural people that the city hospital was best. As this was also a time when patients would often have lengthy stays in hospitals for relatively minor surgical procedures, rural people were encouraged to see their local facilities as being less important or necessary. These same perceptions were also adopted by the health professionals. Ultimately, this meant that the hospital increasingly began to be seen as a centre for post-natal and convalescent care rather than as a hospital able to meet all the

[32]Interview, Former Canterbury Area Health Board member, 2 May 1996.

health needs of its patients. The local feeling for the hospital remained, but people perceived it as not being as necessary as it once was. As a former staff member of Darfield Hospital commented:

> *you went off to see the specialist, and you had your operation, and you stayed in the big city hospital with all the mod cons until you had your sutures out, and then you went home, and . . . while the health dollar was uncapped, I believe a series of conceptions were taken on board by consumers, to the detriment of the little hospital, because people perceived that they didn't need it quite the same, and so it perhaps wasn't as utilised.*[33]

In 1984, the election of the Labour government marked the beginning of a period of rapid and difficult change for rural New Zealand. Under the previous National and Labour governments, New Zealand had developed a highly protected economy which was uncompetitive by international standards. Upon entering office, the new government embarked on a program of radical reform designed to generate sustainable economic growth, and to reduce the level of state involvement in both the public sector and in local government. To achieve this, the government immediately removed the existing subsidies on fertilisers, and the supplementary minimum prices for stock that had previously protected the agricultural sector and given farmers good returns for their products despite low market prices. At the same time, farmers in Europe were being given generous subsidies as the international prices for agricultural goods fell. An increase in the New Zealand exchange rate and a dramatic rise in interest rates also exacerbated this situation.[34] In Canterbury, these changes coincided

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[33]Interview, former Darfield Hospital staff member, 26 April 1996.

[34]For more detail on this see, Ron Sandrey and Russell Reynolds (eds), *Farming Without Subsidies: New Zealand's Recent Experience*, Upper Hutt: Ministry of Agriculture and Fisheries, 1990, and Robert Bremer, "Federated Farmers and the State" in Brian Roper and Chris Rudd (eds), *State and Economy in New Zealand*, Auckland: Oxford University Press, 1993, pp. 108-127.

with a severe drought, and increasing levels of debt as more and more farmers borrowed to survive.

The social and economic costs of these events were devastating to rural communities. Many farmers went bankrupt, and lost not only their properties, but also their livelihoods. Marriages broke up, domestic violence became more prevalent, and suicide became an ever present threat. The stress on families was huge, and this was compounded by women needing to take on additional paid employment to support the family. As one community leader in Darfield described it:

> The carpet was pulled out very quickly. There was very little warning. . . .The stress took its toll. Marriages began to crack and farms began to sell. . . . Bankruptcy ceased to discriminate between good and bad farmers; in the end survival seemed a matter of luck. Rural New Zealand became a catastrophe. Established families who had farmed the land for generations, and which were the foundation for the communities, were not spared. The human cost was enormous. We had 10 marriages break down in 2 months. The gun that I removed from one farmer lay under our bath for a week until I found a safer place.[35]

As a result of these changes to the farming sector, and to wider restructuring that was occurring in the state sector, numerous services to rural areas were withdrawn, with the loss of many local post offices and banking services, railway stations, public transport services, and many retail outlets that closed because of reduced spending power within rural communities. In addition to this, many rural schools were also in danger of closing as pupil numbers declined.[36] This loss of services has been

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[35]Louise Deans, *Perspectives On Land.* Unpublished monograph, 1990.

[36]For further information on the loss of services endured by rural communities, see, Penny O'Leary, "Social Influences on the Health of the Rural Population in New Zealand", *Nursing Praxis in New Zealand,* vol. 6, no. 1, 1990, pp. 15-21, and Canterbury Area Health Board, Secondary Care Division,

keenly felt in rural areas, with virtually all of the people interviewed commenting on how much the rural areas have lost in recent years:

In the last ten years you have seen your local power board disappear, you have seen your Post Offices close down to the point where there is now no Post Office in Selwyn District. . . .Your banking with the Post office, vehicle registration, electoral office has gone. The councils have provided reduced levels of service at Darfield because of amalgamation. All these public service type activities which you were quite justified in thinking you paid your taxes for, have all disappeared on you.[37]

The legacy of these major changes to the rural communities has been to make the remaining services in the community even more highly valued, and to damage seriously the perceptions rural communities have about their own importance. In the aftermath of the rural downturn, rural communities have felt themselves to be undervalued, and to be victims of harsh government ideologies. Despite being major contributors to the national economy, they saw themselves as losing services which people in urban areas did not have to sacrifice, and this created feelings of anger and insecurity. Accordingly, when the transition to an Area Health Board in 1988 saw yet another threat to the rural hospitals in Canterbury, this meant local communities would adopt an aggressive stance. As a community member declared:

We will fight tooth and nail, - we will go through hell and high water to keep it. . . . It's that thing of losing everything from the country.[38]

Report of the Rural Hospitals and Rural Health Needs Review (Akaroa, Darfield, Ellesmere, Lincoln, Rangiora, Waikari), Christchurch: Canterbury Area Health Board, 1991. For a discussion of the impact of the 'rural downturn' on rural families and the role of rural hospitals, see Heather McCrostie Little and Nick Taylor, *Means of Survival? A Study of Off-Farm Employment*, Christchurch: Taylor Baines Associates, 1995.

[37]Interview, Ellesmere community member, 15 December 1995.

[38]Interview, Darfield community member, 31 January 1996.

Impact of the Rural Downturn: The Increasing Importance of Rural Hospitals as Symbols of Community Identity and Security

Against this context of loss of rural services, the attachment of rural communities to their remaining services was heightened, and community perception of the hospitals as symbols of identity, security and health was intensified. The strongest manifestation of this symbolism can be seen in the sense of community ownership towards the hospital. Repeatedly in my interviews, community members would comment the hospital is "ours", and this would often be one of the first things that was mentioned:

It's ours. It is the community's hospital.[39]

. . . we feel the hospital is ours. We support that hospital, we'd do anything for it.[40]

This sense of ownership is fed directly from the communities' perceptions that it was local effort that saw the hospitals built, as one community member commented:

. . . it was built as the result of local people holding countless meetings . . . getting their local authority on board. . . . So, originally, the majority of these country hospitals in these small country towns were not provided by the hospital board, they were provided by the locals, and were ceded to the hospital board. . . largely as the result of local pressures.[41]

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[39]Interview, President Friends of the Darfield Hospital, 22 January 1996.
[40]Interview, Darfield community member, 6 March 1996.
[41]Interview, Ellesmere community member, 29 November, 1995.

In the light of recent political events, this sense of ownership means that the hospital has assumed an enhanced role as a representation of the community's identity and history. As one local councillor commented:

. . . the community paid money to put it there in the early [twentieth] century . . . People were rated to actually get the hospital originally. Some of those people have not forgotten that. So, yeah, it's part of the family silver you might say. Especially if you've paid for or contributed towards getting it up and running. . . .So that's still pretty fresh in one's memory.[42]

In essence, the hospital is being seen as a community asset that represents the giving of past generations. Just as families seek to pass their assets and property on to their children, so too does the community seek to pass on its resources to the next generation. Hence, the hospital is seen as a communal inheritance, and as an extension of family inheritance.

The sense of ownership is expressed through the community's extensive support for the hospitals. Each of the hospitals has a Friends of the Hospital organisation attached to it which raises money for equipment and patient comforts. The people involved in this organisation also maintain a visiting roster, take patients for outings in their cars, arrange flowers, donate goods, and do work at the hospital purely on a voluntary basis. The value of this work, and of the equipment donated, is many thousands of dollars, and from a small community, this represents a substantial contribution. As one member of the Friends of the Ellesmere Hospital commented:

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[42]Interview, Ellesmere community member, 23 January 1996.

. . . to date we've supplied forty or fifty thousand dollars' worth of equipment to the hospital at no charge on the Hospital at all. Just to make life less of a hassle.[43]

Yet communities make this commitment because they perceive the hospital as something owned by themselves, and as providing a valuable and essential service. As such, support for the hospital is widespread across the whole community, with many organisations and individuals regularly fundraising and making donations. As the president of the Darfield Friends of the Hospital commented:

. . . organisations have been very good to us . . . and people are very very good with their donations. . . . People will stop me in the street and say, "I haven't given you anything for the hospital" - and it will be five dollars.[44]

However, the hospitals are not only a critical part of the community's identity, they also represent a personal heritage for many individuals within that community. This sense of having being born at the hospital, or having family born there, was something that was frequently mentioned during the interviews, as one older farmer recalled:

I was a struggling little fellow a long time ago, two of our children were born there, and my eldest daughter went there as well.[45]

Especially in small rural communities which are parochial, family orientated, and dominated by families who have farmed in the area for several generations, many individuals perceive the hospital as being an intimate part of their lives. It is often the place where either they, or their parents and grandparents were born, and it gives them the option

[43]Interview, Ellesmere community member, 23 January 1996.
[44]Interview, President Friends of the Darfield Hospital, 22 January 1996.
[45]Interview, Darfield community member, 10 May 1996.

of being able to die within the community. For rural people, the right to "die under [their] own sky" is highly valued, because dying within the community is more familiar, is more amenable to family and friends remaining near, and offers a quality of death that otherwise may not be obtained.[46] The hospital therefore has an intimate and tangible link with the community, and many people see the building and what it stands for as part of their birthright. As one interviewee commented in relation to Darfield Hospital:

. . . [the] age group that we were socialising with took it as a given. It was always there, it always had been there, and it always would be. It was something that they'd grown up with.[47]

The sense of security provided by the hospital has also been intensified as a result of the loss of services brought about by the rural downturn. As two community members commented:

The hospital reflects a sense of identity for the community, and especially for the elderly. There is an issue of fear there. When you get older, your friends start to die, ill health becomes more prominent. For older people, it represents their security blanket, and they are afraid of losing that.[48]

This village (Darfield) is composed of 65% elderly - retired people. Now that hospital is our security. . . . If I get sick I can go there. If I get sick, the doctors will put me in the hospital. I don't have to go to town. . . . [which is] the high road to hell as far as we're concerned.[49]

This latter comment also touches on the role of the hospital in allowing patients to remain in the community should they become unwell. Especially for rural elderly, the hospital means these patients can remain

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[46]Cited in Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review,* op. cit., p. 57.

[47]Interview, Former Darfield Hospital staff member, 26 April 1996.

[48]Interview, Ellesmere community member, 15 December 1995.

[49]Interview, President Friends of the Darfield Hospital, 22 January 1996.

close to familiar social and personal networks, and the benefit of this was expressed by one community member who commented:

healing is about being in a comfortable place, and a beautiful place, close to friends and family, and knowing that there is that service there, is probably the greatest comfort of all.[50]

These sentiments were also expressed in a local newspaper editorial:

> Darfield Hospital is crucial to continuing local health-care. It provides back-up to the doctors. It provides a place of expert care, 24-hours a day, to those in medical need. The security which this gives to the local community cannot be given a monetary value. Money alone cannot buy the peace of mind. Local knowledge and the skies of home cannot be bought. The benefits of the established, tried and trusted health-care we now enjoy are not for sale. And they most certainly are not to be taken from us merely because some ill informed bureaucrats would have it so.[51]

Today, the legacy of these hospitals' origins is that they are still highly valued by their communities. They have a symbiotic relationship with the community, which is characterised by a process of mutual exchange and dependence, where the needs of each are supplied by the other. The hospitals give medical assistance and employment to the community, and they also give a feeling of security, especially to the older residents, that remains tremendously important even today. As a result, local feeling for the hospital extends right across the community, and this is sustained by the constant contact the community has with the hospital, either through people having friends or relatives in the hospital, or through community efforts to fundraise for it.[52] As a former staff member at Darfield Hospital pointed out:

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[50]Interview, Darfield community member, 17 May 1996.

[51]"Politicians Take Note" *Malvern Record*, Date Unknown.

[52]For a more general discussion of the role of rural hospitals, see Helen Tucker, *The Role and Function of Community Hospitals*, Kings Fund Paper no. 70, London: Kings Fund, 1987.

. . . it wasn't the elderly folk feeling passionate, it was the whole community . . . because of the nature of the hospital services, it touched a whole range of people.[53]

Ultimately, this attachment to the hospital meant that when the next serious threat to the hospitals was initiated by the Area Health Board, the rural communities would resist the threat with all their strength.

. . . there would have been opposition to hospital closure anyway, but the threat of hospital closure on top of all the other closures over which you had absolutely no ability to influence whatsoever, bang, everyone was in like Flynn.[54]

The Area Health Board Years 1988 - 1991: Renewed Threat and a Narrow Escape for Rural Hospitals

In the late 1980s, the pace of economic change in New Zealand began to accelerate rapidly. Rural communities, battered by the events of the past few years, were struggling to cope with the feelings of betrayal and disillusionment created by the economic downturn. However, as the 1980s drew to a close, the atmosphere of fiscal constraint that had been fostered by the policies of the Labour government was still very strong, and was particularly evident with spending on health. In 1988, the government moved to make Area Health Boards compulsory, and introduced measures to make these Boards more efficient. Area Health Boards were now significant because, for the first time, they represented a statutory organisation that was concerned with the total health of its population. This philosophy was reflected in the objectives of the Area

[53]Interview, Former Darfield Hospital staff member, 26 April 1996.
[54]Interview, Ellesmere community member, 15 December 1995.

Health Boards which were defined under the Area Health Boards Act (1983) as being:

> a. to promote, protect and conserve the public health, and to provide health services.
>
> b. to provide for the effective coordination of the planning, provision, and evaluation of health services between the public, private and voluntary sectors.
>
> c. to establish and maintain an appropriate balance in the provision and use of resources for health protection, promotion, health education and treatment services.

In 1989, the Canterbury Board initiated an Expenditure Reduction Taskforce, and one of the recommendations made by that Taskforce was the closure of six of the Board's nine country hospitals.[55] At this time, all the Area Health Boards were coming under significant pressure to reduce their expenditure, and throughout the Area Health Board, services were being more closely evaluated to determine if they were giving true benefits in proportion to their costs. As a former Canterbury Area Health Board staff member commented:

. . . the Area Health Board reforms had definitely begun to make people think much harder about things like financial accountability, and were services value for money.[56]

However, fuelled by the events of the mid 1980s, opposition to the suggested closures was intense, and submissions and public meetings held by the Board reflected the community's disapproval. In light of that opposition, the Board decided to delay any decisions on the future of

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[55]Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review,* op. cit., pp. 19-20.

[56]Interview, Former Canterbury Area Health Board staff member, 22 February 1996.

those hospitals until a review of their role and function could be carried out. So in late 1990 a review was initiated for Darfield, Ellesmere, Lincoln, Akaroa, Rangiora and Waikari Hospitals.

To carry out the review, the manager of the Secondary Care division convened a working party which commenced its operations in late 1990. In conducting the review, the working party engaged in a consultative process to gather information from a variety of sources. Notably, this included advertising the review in the media, holding informal meetings with the staff and medical superintendents of the rural hospitals, having public meetings in each of the areas which were also attended by the local Councils, and receiving written submissions from individuals and groups. Community response to the review was once again very vocal, and relied on traditional methods of lobbying. These included writing letters and submissions to the members of the Board, high community turn out at public meetings, and publicising the case of the hospitals where possible.[57]

The review was extremely important for the rural hospitals because they were being strongly perceived as an easy area in which to make reductions because of their high cost and low utilisation rates. As a former Canterbury Area Health Board staff member commented:

I think there probably was a sense they were proportionately consuming more resources than could be afforded in terms of all the other pressures on the Area Health Board budget at the time.[58]

With the much greater emphasis on financial accountability than had existed in the past, this latest episode represented the most serious threat

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[57]Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review,* op. cit.

[58]Interview, Former Canterbury Area Health Board staff member, 18 May 1996.

rural hospitals had experienced to date. Throughout the history of the Hospital Board, there had been tensions between rural and urban members over the costs and benefits of rural hospitals, but these tensions manifested themselves much more explicitly in this period, and the push by urban administrators to shut the hospitals was very strong. This view was expressed by a member of the review team:

I suspect part of the agenda was the question, unspoken, can we do without any of them? Can we close any of them? I don't think that was ever said . . .but I had this fairly strong feeling that this was an unspoken question in conducting the review in the first place.[59]

However, it is also important to note that some hospitals were seen as being less justified than others, primarily because of their closeness to Christchurch. There was certainly a perception within the Area Health Board that people living in areas like Ellesmere, Rangiora and Darfield, could be sacrificed to provide services in other more isolated areas like Kaikoura, Waikari, and Akaroa, and as such areas. As a former Canterbury Area Health Board staff member pointed out:

. . . one has to take a fairly hard line. . . .The wider good for people . . . of an Area Health Board [is] to be sure that the money is being spent in terms of best outcomes for the total population. . . .If you're reasonably close to a big city with a full range of hospital related services like Darfield or Rangiora or Ellesmere which are inner ring hospitals, is that so much of a hardship to travel thirty or forty minutes . . . for those comprehensive services? [60]

The ongoing tension meant that long serving members from the rural areas developed good political skills which allowed them to use the

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[59]Interview, Former Canterbury Area Health Board staff member, 22 February 1996.
[60]Interview, Former Canterbury Area Health Board staff member, 28 May 1996.

institutional structure to their advantage. This can be very clearly seen in the decision to conduct a review by Mrs Gardiner. She commented:

. . . while many of the town members supported this idea of reducing the services in the country areas through country hospital closure, there were one or two who were sympathetic towards them, and politically it was easier to put things off. . . to say I suggest we have a review of the country hospitals in order to determine their viability, and their need . . . this was a ploy I used sometimes to prevent the immediate closure of those hospitals.[61]

Primarily, she was able to argue that it was the Area Health Board's responsibility to provide for the total health needs of its catchment population, and as such it needed to look at the hospitals in the context of total health services in rural areas. As a former Canterbury Area Health Board staff member recalled:

The argument was very strong, that if you were having integrated services, you had to look at the whole lot. It was no good seeing the hospitals in isolation and saying that's it, without looking at what other services are going to take their place.[62]

However, it is important to recognise that attempts to protect the hospitals went beyond one member acting in isolation: there was a concerted effort by the supporters of the rural hospitals. This included key people from the Board's administrative staff, and the communities themselves who were able to organise efficiently to resist the threat. As a former Canterbury Area Health Board staff member pointed out:

. . .the rural communities on the whole can work very coherently together. It doesn't take a great deal of effort to get a rural community to turn out a

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[61]Interview, Former Canterbury Area Health Board Member, Mrs June Gardiner, 16 February 1996.
[62]Interview, Former Canterbury Area Health Board staff member, 9 July 1996.

meeting of several hundred vocal people, who know exactly what they want, and are not frightened to say so to anybody who comes from an urban area.[63]

It makes a very strong impact on urban administrators when rural communities turn out in large numbers to support their hospitals. This also represented a form of lobbying that was very effective for communities, primarily because it exploited the close links that the elected members of the Board felt they had with the people they represented. Repeatedly in interviews, community members would comment on how Board members and staff from the Area Health Board would be amazed at the depth of feeling that the communities had for their hospitals. Hence, with the support from within the Board by the rural members, communities were successful in opposing unpopular decisions like the closing of rural hospitals. As a former Canterbury Area Health Board member commented:

. . . mostly the case was so obvious as to where the community stood that the bean counters had to step back as it were, and give in.[64]

Upon completion of the review, a report was written, recommending that all the rural hospitals in the review be retained.[65] This report was accompanied by a commentary from the manager of the Secondary Care division in which he outlined four options for the Board to consider. Included amongst these options was the closure of Ellesmere Hospital, and the maternity and general medical care beds at Darfield and Ellesmere be changed to provide only day care.[66] When both reports

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[63]Interview, Former Canterbury Area Health Board staff member, 9 July 1996.

[64]Interview, Former Canterbury Area Health Board member, 2 May 1996.

[65]Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review (Akaroa, Darfield, Ellesmere, Lincoln, Rangiora, Waikari),* Christchurch: Canterbury Area Health Board, May 1991.

[66]Winston McKean, *Report of the Rural Hospitals and Rural Health Needs Review,* Internal memo from the Manager, Secondary Care Division to the Canterbury Area Health Board, 21 June 1991.

were presented to the Board, it is widely acknowledged that it was June Gardiner who persuaded the Board to accept the report's recommendations that all the hospitals be retained. As her case was supported by figures that showed it would be more expensive to provide alternative services should the rural hospitals be closed, the recommendations were accepted for Akaroa, Lincoln, Waikari and Rangiora hospitals.[67] In the case of Darfield and Ellesmere hospitals, however, it was agreed to refer the issue of closure to the Community Affairs and Public Relations Committee for further consideration. The timing of this meeting was also a critical factor in preventing the closure of the hospitals. This was because it was very soon after this that the health reforms were announced, the Area Health Boards were disestablished, and all major efforts to reorganise services were held in abeyance.

Conclusions

In 1991, the rural hospitals in Canterbury were extremely fortunate to escape closure. On this occasion, it was the political skills of the rural Board members, and the intense public opposition in rural areas to the possibility of closure that were sufficient to persuade the Board once again that the hospitals needed to remain open. Yet this outcome highlighted very clearly what the reformers saw as the structural weaknesses of the Area Health Board system that the reformers argued prevented the efficient operation of the health system. Skilful representatives could block what the reformers saw as measures to improve the efficient operation of the health system. Consequently,

[67] A financial analysis of the costs of providing alternative services to rural areas should the rural hospitals be closed found significant increases for the Canterbury Area Health Board. See, Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review*, op. cit., Appendix 8, p. 1.

the health reforms were designed to shift power from the community to the 'bean counters' by replacing largely elected Boards with entirely appointed ones, and requiring them to 'consult' with communities only over changes to the range of services available in their localities. It was hoped that this would insulate the RHAs from these kinds of community pressures, and so enable them to make difficult and unpopular rationing decisions.

Chapter Three: Theoretical Framework and the Health Reforms

Introduction

As discussed in Chapter Two, debates over rural hospitals involve considerably more for local communities than the loss of an aging building. Such debates, however, are not confined to rural areas but point further to deeper issues of power and control that are endemic within health systems. As local communities and health organisations struggle over specific buildings, they invoke broad interests which can be found in health systems throughout the world. As actors, local communities and health organisations have their own preferences and goals, and engage in a mixture of competition and collaboration with each other to have those goals satisfied. This competition and collaboration occurs in a political arena comprised of and regulated by specific institutions, and it is these institutions which have the effect of privileging some interests and disadvantaging others.

This pattern of institutional influence is particularly relevant to New Zealand because the last five years have witnessed a radical change in the institutional structure of the health system. This change involved a deliberate attempt to re-weight the strengths of the key actors in the health system to produce new outcomes in their conflicts. By weakening the power of communities and providers and strengthening the position of managers and appointed Boards working in the health administrative bodies, it was hoped local communities would no longer be able to exert such political pressure as they had in the past been able to use to block the rationing decisions of Area Health Boards. The key to this strategy was the abolition of Area Health Boards and the

introduction of a 'managed market' into the health system. Correspondingly, this chapter aims to investigate effects of this change to a 'managed market' system, using two complementary analytic approaches: the 'new institutionalist' framework; and structuralist theory, based on the work of Robert Alford, with additional aspects from the work of Ellen Immergut.[1]

The New Institutional Framework

In recent years, the role of institutions in political, social and economic life has been the subject of renewed interest in many academic disciplines. As Powell and DiMaggio state:

> There are, in fact, many new institutionalisms - in economics, organisational theory, political science and public choice, history and sociology - united by little but a common conviction that institutional arrangements and social processes matter.[2]

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[1]It is also important to recognise that there are many different ways to study the nature and exercise of power within health systems, including for example, Marxist approaches, pluralist approaches, and political economy approaches. Each of these perspectives has its own assumptions about the nature of society and the behaviour and characteristics of groups and individuals, and consequently brings its own unique insights into the study of power. However, the focus of this thesis is not so much to explore and debate theory as to find conceptual tools to trace the effects of changing institutional forms on the relative power of different actors located within the health system. Hence, a 'new institutionalist approach' was considered to be the most useful framework to use. For readers interested in these other approaches, see among others, the work of V. Navarro, *Medicine Under Capitalism*, New York: Prodist, 1976 for a Marxist approach. Pluralist ideas have best been encompassed in the work of D B Truman, *The Government Process*, New York: Knopf, 1951, and in R. Dahl, *Who Governs?* New Haven: Yale University Press, 1961, and have been applied to the British health system in work by H. Eckstein, *Pressure Group Politics*, Allen and Unwin, 1960 and A. J. Willcocks, *The Creation of the National Health Service*, Routledge and Kegan Paul, 1967. The work of Marmor and Christianson in T. Marmor and J. B. Christianson, *Health Care Policy: A Political Economy Approach*, Beverley Hills: Sage, 1982 also demonstrates the political economy approach, as does the very recent work of James Conner in the New Zealand setting, see James Conner, *The Political Economy of Health Care in New Zealand: A Comparative Analysis*. Unpublished PhD Thesis, Christchurch: University of Canterbury, 1995. For a work that attempts to distinguish and synthesise these different approaches, see the classic publication of Steven Lukes, *Power: A Radical View*, London: Macmillan Press, 1974. Institutionalist approaches can in some ways be considered as attempts to analyse further Lukes second and third dimensions of power. See for this argument Peter Hall and Rosemary Taylor, "Political Science and the Three Institutionalisms", *Political Studies*, vol. 44, no. 5, 1996, pp. 936-957.

[2]Paul DiMaggio and Walter Powell, "Introduction" in Walter Powell and Paul DiMaggio (eds), *The New Institutionalism in Organisational Analysis*, Chicago: University of Chicago Press, 1991, p.3.

In political science, the study of institutions has long been a central aspect of the discipline, but the importance given to institutional variables has changed over time as new approaches to the study of political life have risen and fallen in popularity amongst scholars. Prior to the 1950s, the study of institutions dominated the discipline, but much of this work comprised primarily descriptive studies of different administrative, legal and political structures, with analysis confined to comparing and contrasting the institutional structures across countries.[3] With the onset of the behavioural revolution in the 1950s and 1960s, the emphasis changed from studying the formal structures of various governmental institutions to understanding how the informal distributions of power, and the attitudes and behaviours of individuals and groups, explained the outcomes of political conflicts.

Developing at approximately the same time as the behaviouralist revolution was the rational choice school of thought. This approach closely overlaps with what March and Olsen have identified as the exchange perspective. In this perspective, politics is seen as the aggregation of individual preferences into collective actions by procedures of negotiation, bargaining, coalition formation and exchange.[4] Politics is viewed as a "market for trades" in which individuals and groups are perceived as self-interested, rational actors who act to maximise their preferences. Individual actors are assumed to have stable, consistent and exogenous preferences, and they pursue those preferences by considering alternative bargains in relation to their

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[3]Kathleen Thelen and Sven Steinmo, "Historical Institutionalism in Comparative Politics" in Sven Steinmo, Kathleen Thelen, and Frank Longstreth (eds), *Structuring Politics*, Cambridge: Cambridge University Press, 1992. See also Haans Daalder, "The Development of the Study of Comparative Politics", in Hans Keman (ed), *Comparative Politics: New Directions in Theory and Method*, Amsterdam: VU University Press, 1995, pp. 11-30.

[4]James March and Johan Olsen, "Institutional Perspectives on Political Institutions", *Governance*, vol. 9, no. 3, 1996, p. 248.

"expected consequences", and choose the combinations of bargains that optimise their preferences. Collective action is dependent on the willingness of sufficient numbers of political actors to make a change, and on the negotiation of bargains and side-payments among potential trading partners. The ability of any actor to realise his/her desires in this system is dependent on what those desires are, what exchangeable resources the actor has, and what political rights the actor is entitled to. The greater the exchangeable resources, and the more rights to political voice, the stronger the position of the actor to trade.[5]

Both the behaviouralist and the exchange perspectives have been criticised for leaving unexamined the role played by institutions in explaining political outcomes. Eventually this difficulty fostered the development of a new approach to the study of politics and policy making, one which "rediscovered" institutions, and the significance of institutional variables in explaining the outcomes of political conflicts. This alternative approach is classified by March and Olsen as the institutional perspective, and emphasises the role of institutions in political life.[6] The 'new institutionalist' approach argues for the primacy of institutions in shaping the goals and strategies of actors, and in influencing the outcomes of political struggles between those actors.

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[5]ibid, p.249.

[6]For development of the new institutionalist approach, see the work of J. March and J. Olsen, "The New Institutionalism: Organizational Factors in Political Life", *American Political Science Review*, vol. 78, 1984, pp. 734-749; J. March and J. Olsen, *Rediscovering Institutions*. New York: Free Press, 1989; J March and J Olsen, *Democratic Governance*, New York: Free Press, 1995; Theda Skocpol, *States and Social Revolutions*, Cambridge: Cambridge University Press, 1979; Theda Skocpol, "Bringing the State Back In: Strategies of Analysis in Current Research" in Peter Evans, Dietrich Rueschemeyer, and Theda Skocpol (eds), *Bringing the State Back In*, New York: Cambridge University Press, 1985; Suzanne Berger, "Introduction" in Suzanne Berger (ed), *Organizing Interests in Western Europe*, Cambridge: Cambridge University Press, 1981; Peter Katzenstein, *Between Power and Plenty*, Madison: University of Wisconsin Press, 1978; Peter Hall, *Governing The Economy: The Politics of State Intervention in Britain and France*, New York: Oxford University Press, 1986.

However, even within this institutional perspective, there are different understandings of the role played by institutions. Koelble has identified two broad groups of new institutionalists, one developing from rational choice and the other from strands in political science and sociology, 'historical institutionalism'.[7] 'Rational choice institutionalists' perceive individuals as rational actors seeking to maximise their self-interest, and hence treat institutions only as an "intervening variable capable of affecting an individual's choices and actions but not determining them."[8] In contrast, the historical institutionalists argue that institutions play a more determinant role, shaping the choices, strategies and goals of individuals and groups. Thelen and Steinmo argue that institutions mediate the "relations of cooperation and conflict" between political actors, and in so doing structure political situations.[9]

As Peter Hall emphasises, this institutionalism focuses on the "relational character" of institutions, or the way in which they configure the interactions of political actors.[10] Institutions do this in a number of ways. North argues that institutions are the "rules of the game in a society," that is, they represent humanly created constraints that structure interactions between individuals and groups,[11] providing political actors with consistent rules of behaviour, conceptions of reality, standards of assessment, affective ties and endowments, and thus with a

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[7]Thomas Koelble, "The New Institutionalism in Political Science and Sociology", *Comparative Politics*, vol. 27, 1995, p. 232. For examples of rational choice institutionalists, see the work of Karen Cook and Margaret Levi (eds), *The Limits of Rationality*, Chicago: University of Chicago Press, 1990; Douglass North, *Institutions, Institutional Change and Economic Performance*, Cambridge: Cambridge University Press, 1990.

[8]Koelble, "The New Institutionalism in Political Science and Sociology", op. cit., p. 232.

[9]Thelen and Steinmo, "Historical Institutionalism in Comparative Politics", op. cit., p. 9.

[10]Hall, *Governing The Economy*, op. cit., p. 19.

[11]Douglass North, *Institutions, Institutional Change and Economic Performance.*, op. cit., p.3.

capacity for purposeful action. Institutional structures also create rules regulating the possession and use of political rights and resources.[12]

As a result, the institutional arrangements of any particular system will affect the interactions of political actors, most notably by privileging some, and disadvantaging others. Institutions therefore structure the battles that occur between the different political actors in the polity, and in so doing, influence the outcomes of those struggles. This is particularly relevant for health policy and for rural hospitals because as Immergut shows, institutions explain policy outcomes

> . . . precisely because they facilitate or impede the entry of different groups into the policy making process. Different procedures for making policy decisions frame policy debates: They change the array of actors that are brought into the decision making process, and they provide distinct sets of advantages and disadvantages to groups wishing to promote their interests.[13]

The definition of the term institution, however, is a source of much debate in the literature. Historical institutionalist theorists work with definitions of institutions that include both the formal structures of polities, as well as informal rules and procedures that govern behaviour. Hence, they are interested in a range of state and societal institutions that mould the interests of political actors, and structure their power in relation to other groups. These may include such things as constitutional rules and the structure of party systems, as in the work of Ellen Immergut, as well as what March and Olsen identify as "systems of law, social organisation (such as the media, markets, or the family),

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[12]March and Olsen, "Institutional Perspectives on Political Institutions", op. cit., pp. 249-251.

[13]Ellen Immergut, *Health Politics: Interests and Institutions in Western Europe*, Cambridge: Cambridge University Press, 1992, p. xii.

and identities or roles (such as "citizen", "official", or "individual)."[14] However, for the purposes of this thesis, Peter Hall's definition of institution will be used. Hall treats institutions as "the formal rules, compliance procedures, and standard operating practices that structure the relationship between individuals in various units of the polity and economy."[15]

Historical institutionalism also takes into account the role of time. Time is a crucial factor because it helps to explain why actors develop particular goals, and why they favour some goals over others. An historically based analysis is also important to understanding how and why an actor's preferences and strategies change, and the role of institutions in causing that change. This is particularly relevant to New Zealand because the goals of central government and local communities have remained relatively constant, but the strategies these actors employ to satisfy their goals have radically changed as the institutional structure of the system has altered.

Ellen Immergut and Veto Points

The work of Ellen Immergut has developed the field of historical institutionalism by emphasising the importance of veto points. In her work, Immergut sought to explain how attempts to introduce national health insurance policies in France, Sweden and Switzerland produced different policy outcomes in each of the three countries. Notably, she found the ability of the medical profession to successfully oppose national health insurance proposals varied across countries. If the profession was everywhere opposed to national health insurance, the

[14]March and Olsen, *Democratic Governance*, op. cit., p. 27.
[15]Hall, *Governing The Economy*, op. cit., p. 19.

political outcomes of that opposition were quite different, ranging from rejection of the proposal in Switzerland; the introduction of a compulsory public insurance program that paid for medical treatment by private doctors in France; while a de facto national health service providing medical treatment directly to citizens through publicly employed doctors in state hospitals was introduced in Sweden.[16]

To account for these differences between her cases, Immergut identifies the institutional structure of each state, and specifically, the location of veto points within that structure. She argues that it is the institutions which establish the 'rules of the game' for politicians and interest groups seeking to enact or to block certain policies. Veto points are places of strategic uncertainty or institutional vulnerability where the mobilisation of sufficient opposition can block policy proposals. Immergut shows that political decisions are not single decisions made at any one point in time, but are instead comprised of a sequence of decisions made by different actors at varying institutional locations. Hence, to reach a decision, such as the passing of a piece of legislation, affirmative votes must be given at all the decision making points. The power of interest groups, such as physicians, to influence these decisions depends on their ability to control those veto points so that the key individuals in those decision making points will block the proposed action. Crucially, then, she argues that interest group power, and specifically the presence or absence of medical dominance, "depends on the veto points within political systems and not on the properties or organisation of particular groups."[17]

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[16]Immergut, *Health Politics: Interests and Institutions in Western Europe*, op. cit.

[17]ibid, p. 32. See also Ellen Immergut, "The Rules of the Game: The Logic of Health Policy Making in France, Switzerland, and Sweden" in Sven Steinmo, Kathleen Thelen, and Frank Longstreth (eds), *Structuring Politics*, Cambridge: Cambridge University Press, 1992, p. 63.

For Immergut, the location of veto points is not random, but is dependent on the constitutional provisions which establish the formal rules for the division of power between first, the elected representatives, and second, the electoral results and the characteristics of the party system. Together these 'de jure' constitutional rules and 'de facto' rules of the electoral and party system create the background against which politicians, bureaucrats and interest groups act to either support or resist policy proposals. Immergut asserts that these institutional rules do not predetermine policy outcomes, but instead change the course of policy making by the way the rules "link particular decision makers, or allow them greater or lesser independence of action."[18] However, she also argues that by establishing the rules of the game, institutions enable observers to predict the ways in which policy debates will be played out.

Robert Alford's Theory of Structural Interests

If Immergut's work focuses on how the institutional framing of decisions shapes the outcomes of struggles among health system actors, Robert Alford's work points to who those actors are. In his chief work, *Health Care Politics*, Alford examines the New York health care system and argues that modern health systems produce three types of structural interests: dominant interests, represented by 'professional monopolists'; challenging interests, represented by 'corporate rationalisers'; and 'repressed interests', who correspond to local community populations.[19]

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[18]Ellen Immergut, *Health Politics: Interests and Institutions in Western Europe*, op. cit., p. 27.

[19]Robert Alford, *Health Care Politics*, Chicago: Chicago University Press, 1975. Alford's work is a classic account of the interests produced by modern health systems, and has fostered a body of work that develops his framework to explore the location of power within health systems, and how conflicts between competing interests are resolved. For examples of Alford applied in the British context, see the work of Christopher Ham, *Health Policy in Britain: The Politics and Organisation of the National Health Service*, London: Macmillan, 1981; Judy Allsop, *Health Policy and the National Health Service*, London: Longman, 1984; Gerald Wistow "The Health Service Policy Community: Professionals Pre-eminent or

Within the health system itself, Alford saw the medical profession as the dominant structural interest; the heads of medical schools, insurance companies, and hospitals as the corporate rationalisers; and disadvantaged community populations as repressed interests.

Alford contends that these groups are engaged in a continual struggle for power over the control of key health care resources and institutions. As this struggle occurs in a system that is strongly influenced by the biomedical model which privileges the professional monopolisers, corporate rationalisers and especially local communities are never able to emerge as victors, and can only ever achieve a stalemate with the more advantaged groups. Alford also argues that as a consequence of this control by the dominant structural interests, efforts by bureaucratic and market reformers, the 'corporate rationalisers,' to resolve the 'crisis' afflicting health care do not produce substantial change, but instead create a system of "dynamics without change."[20]

Alford's Structural Interests

In Alford's classification, the medical profession are the most important group of professional monopolists.[21] As the dominant structural interest

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Under Challenge?" in David Marsh and R Rhodes (eds), *Policy Networks in British Government*, Oxford: Clarendon Press, 1992; Nancy North, "Alford Revisited: The Professional Monopolisers, Corporate Rationalisers, Community and Markets", *Policy and Politics*, vol. 23, no. 2, 1995, pp. 115-125. For Alford applied in the Australian context, see G. R. Palmer "Social and Political Determinants of Changes in Health Care Financing and Delivery" in A. Graycar (ed), *Perspectives in Australian Social Policy*, Melbourne: Macmillan, 1978; S. Duckett, "Structural Interests and Australian Health Policy", *Social Science and Medicine*, vol. 18, 1984, pp. 959-966. For a comparative study of Alford applied in both the Swedish and British contexts, see Christopher Ham, "Governing the Health Sector: Power and Policy Making in the English and Swedish Health Services", *The Milbank Quarterly*, vol. 66, no. 2, 1988, pp. 389-414.

[20]Robert Alford, "The Political Economy of Health Care: Dynamics Without Change", *Politics and Society*, vol. 3, 1972, p. 128.

[21]Among the medical profession, Alford includes physicians, specialists, and researchers working in both universities and medical schools who not only gain income from private practice, foundations, universities, and government, but are also able to exploit organisational resources to further their professional and personal interests.

in the system, Alford argues the medical profession are served by the existing network of social, political and economic institutions of the system. Hence the profession has no need to organise continuously to defend their interests, nor any desire to change the status quo. Alford classifies them as monopolistic because "they have nearly complete control over the conditions of their work" and this control is "buttressed" by the traditions and status of their profession.[22]

The principal activity of the professional monopolisers results in an increase in programs and projects, such as clinics, health centres, and outreach units from major hospitals. Although these facilities improve the delivery of health services, they are primarily established to provide advantages for the professional monopolists such as research, training, and professional status. These programs are then justified through a "continuous flow of symbols" which not only legitimate the programs, but also prevent attempts by other groups to gain control of them by "reassuring" the agencies and constituencies to whom the medical profession is accountable.[23]

Alford argues that maintaining their autonomy and control is a common goal of the professional monopolists, and they will mobilise to defend this interest when it is challenged. In Alford's account, challenges to the control of the medical profession come from the corporate rationalisers. Corporate rationalisers are the personnel occupying the top positions in a variety of health organisations, and encompass hospital administrators, the heads of some quasi public insurance companies, state and federal health officials, directors of city

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[22]Alford, *Health Care Politics*, op. cit., p. 194.
[23]Ibid.

health agencies, public health officials, and medical school directors. Driven by changes in technology and in the organisation of health care, corporate rationalisers have an ideology that seeks "a rational, efficient, cost-conscious, co-ordinated health care delivery system".[24] In light of modern, hospital based technology, they see the medical division of labour as "arbitrary and anachronistic," and as a result, they endeavour to unify resources and services under one central organisation.[25] As a result, individual corporate rationalisers have strong incentives to expand the size and resources of their organisations, especially as any expansion is likely to accrue additional income and prestige. However, Alford contends that as corporate rationalisers are unable to control all of the factors in the production of health, they are unlikely to achieve full co-ordination in practice.[26]

Alford also argues that this consequence is hidden by the rhetoric of the corporate rationalisers which suggests that social or political mechanisms can be created which would unify and integrate the system. In contrast, Alford contends that these mechanisms do not exist, and suggests that attempts to integrate the system result only in the creation of further agencies, usually without the power to fulfil their objectives. The actions of corporate rationalisers frequently result in an expansion of the functions, powers and resources of their own organisations, the overall impact of which is to further complicate both the private and public bureaucratic structures.[27]

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[24]Ibid, p. 204.
[25]Ibid.
[26]Ibid, p. 205.
[27]Ibid, p. 208.

Alford's chief argument is that the emergence of the corporate rationalisers challenges the interests of the professional monopolisers. Although he states that the two groups exist in a symbiotic relationship, and can form alliances to achieve certain objectives, he also asserts that the corporate rationalisers are united by a common interest in extending the control of their organisations over the conditions of work, income, and division of labour of physicians. This results in a continuous struggle for power between these two groups, but it is a conflict the corporate rationalisers can never win because the conflict occurs in an institutional context which always favours the professional monopolists. As a result, Alford argues that corporate rationalisation will always remain an 'ideal' because systemic barriers ensure that the corporate rationalisers will never gain the necessary support or social power to fully integrate and co-ordinate health care.

The third grouping in Alford's classification are local communities in need of health care, and particularly white rural and urban poor, ghetto blacks, lower middle class families just above the Medicaid income threshold, and middle class families rendered medically indigent through escalating health care costs. Alford considers these populations repressed interests because they are guaranteed not to be served by the institutional structure, unless "extraordinary political energies" can be generated.[28] These groups are represented by the equal health advocates who demand improved health services, as well as greater community participation in the decisions affecting health care. Alford contends, however, that the efforts of these individuals and groups will usually fail. Regardless of whether they focus their demands on a particular program or need, or on reform of the system, they unwittingly give

[28]Ibid, p. 14.

legitimacy to the activities of either the professional monopolists, through the establishment of further programs, or to the corporate rationalisers, through the creation of new agencies with no real ability to co-ordinate or integrate the system. The result is that the system ends up moving in the opposite direction to that intended.[29]

Alford also argues that community participation is most likely to lead to a situation of stalemate. Even when community groups are mobilised, they tend to become embroiled in conflicts amongst themselves and with other groups over such issues as funding, location, timing and control. As a result, their own actions can effectively prevent new programs or projects from coming to fruition, although Alford contends that the system works anyway to bring about this stalemate. This is because the structure of the system acts to ensure that neither the interests of the professional monopolists nor these of the corporate rationalisers are damaged. This occurs either through the requirement of "consensus," which necessitates the viewpoints of all groups being heard but ensures that none of them are implemented except those of the dominant interests, or by ensuring that the decision making bodies on which the community groups are represented do not have sufficient power to effect change.[30]

Historical Institutionalism, Immergut and Alford in New Zealand

In New Zealand the structural interests described by Alford can be readily identified, although there are some key differences in the composition and strength of those interests than in Alford's account. Doctors still constitute the professional monopolists, but in New Zealand local

[29] Ibid, pp. 218-220.
[30] Ibid, p. 221.

communities consist of all communities and not just the poor and medically indigent. The corporate rationalisers comprise actors in the health sector who are principally concerned with the efficient operation of the sector, Treasury and assorted business interests who have been drawn into the health system as sources of independent advice.

In the last decade, the interests identified as the corporate rationalisers have grown in prominence in the New Zealand health sector. This has occurred in conjunction with the rise of the New Right ideology. This ideology has placed a stronger emphasis on reducing the role of the state in the provision of welfare services and allowing market principles to govern the allocation of scarce resources. A key actor in the promotion of the New Right philosophies has been Treasury. After the economic stagnation and crisis that developed in the early 1980s, it was Treasury, supported by various private sector groups, who assumed a critical role in designing and implementing much of the reform that they argued was necessary to improve the country's economic performance.[31] Over time, the recurrence of fiscal crises has allowed these interests the opportunity to extend their authority into the health sector, and to become extremely powerful in determining the restructuring of the sector.

What is distinctive about New Zealand, however, is that the means through which this grouping seeks to achieve its aims has undergone a dramatic change in the last fifteen years. Whereas in Alford's account,

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[31]For the influence of Treasury on social and economic policy, see for example, Jonathon Boston, "Treasury: its Role, Philosophy and Influence" in Hyam Gold (ed), *New Zealand Politics in Perspective*, 3rd ed., Auckland: Longman Paul, 1992, pp. 194-215; S. Goldfinch and B. Roper, "The Treasury's Role in State Policy Formation" in Brian Roper and Chris Rudd (eds), *State and Economy in New Zealand*, Auckland: Oxford University Press, 1993; Colin James, *New Territory*, Wellington: Bridget Williams Books, 1992; Jane Kelsey, *Rolling Back the State*, Wellington: Bridget Williams Books, 1993; Jane Kelsey, *The New Zealand Experiment*, Auckland: Auckland University Press, 1995; J. Deeks and N. Perry (eds), *Controlling Interests*, Auckland: Auckland University Press, 1992; Brian Easton (ed), *The Making of Rogernomics*, Auckland: Auckland University Press, 1989; Ruth Richardson, *Making A Difference*, Christchurch: Shoal Bay Press, 1995.

corporate rationalisers relied on bureaucratic mechanisms to achieve their aims, in New Zealand these mechanisms have been supplanted by the use of market disciplines. Hence from the mid 1980s, corporate rationalisers have become increasingly reworked as market rationalisers. In his work, Alford argued the corporate rationalisers could never win over the professional monopolists because the system always acted to protect the interests of the dominant group. In New Zealand, however, it has been this very argument that has allowed the market rationalisers to be so influential in the restructuring of the health sector. The market rationalisers have contended that 'capture' of the health system by the medical profession and local communities acts as a barrier to the efficient operation of the system. Consequently, the corporate rationalisers have argued the need for an institutional structure that embodies market disciplines, and privileges their interests over those of providers and communities. However, as Chapters Four and Five argue, the outcomes of this new institutional structure have not always turned out as the market rationalisers anticipated.

Reform of the New Zealand Health System: 1974-1991

The first major initiative to reform the health service in New Zealand came in 1974 with the third Labour government's White Paper, *A Health Service For New Zealand.*[32] At this time, the health system was virtually controlled by the medical profession and locally elected Hospital Boards, who oversaw the distribution of resources in secondary care. Between 1967 and 1971, however, poor economic performance and rising levels of international debt began to put pressure on the health budget, and the government became increasingly concerned about its

[32]New Zealand Government, *A Health Service for New Zealand,* Wellington: Government Printer, 1974.

ability to fund the open ended commitment to health care contained in the 1938 Social Security Act. Despite a brief period of prosperity between 1972 and 1974, economic concerns meant the government began focusing on finding ways to contain health care costs, and ensuring that services were cost effective.

A Health Service For New Zealand identified the key problems of the health sector as stemming from the 'fragmentation' that existed in the funding, delivery and organisation of the system. At that time, the health system featured both public and private providers, locally elected Hospital Boards governing hospital services, district offices of the Department of Health delivering public health services, and from 1974, the Accident Compensation Corporation as a second public funder of accident victims. Like the corporate rationalisers as Alford defined them, reform of the administrative structure through an overarching bureaucratic mechanism was still considered the most appropriate way to address the problems of the health system.

At the heart of the proposals was a New Zealand Health Authority which would assume responsibility for priority setting, policy making and strategic planning at the national level. It would replace the Department of Health, and was to "provide leadership to match its funding of the new regional authorities."[33] This Authority would be complemented by fourteen Regional Health Authorities which would replace the existing Hospital Boards, and would plan, provide, and develop health services in the public, private, and voluntary sectors. Together, these agencies would overcome the problems of fragmentation

[33]John Martin, "Devolution and Decentralisation" in Jonathon Boston, John Martin, June Pallot and Pat Walsh (eds), *Reshaping The State: New Zealand's Bureaucratic Revolution*, Auckland: Oxford University Press, 1991, p. 278.

by producing a "co-ordinated, comprehensive and functionally integrated health service."[34]

However, these proposals proved to be highly contentious and engendered much hostility among the groups who benefited from the existing system.[35] Elected boards resented the loss of status that the shift to Regional Health Authorities would entail, and the medical profession opposed the reforms on the basis that they would allow central government to have greater control over doctors.[36] This created a strong reaction amongst the medical profession, with a *New Zealand Medical Journal* editorial claiming the proposals would create an "authoritarian monster" that would be imposed "not only on the medical profession but on the people of New Zealand".[37] As a result, the reforms were never implemented, and were widely believed to have contributed to the Labour government's defeat in the subsequent election.[38]

However, *A Health Service for New Zealand* is vitally important to understanding the history of health reform in New Zealand, not only because of the nature of its proposals, but also because "its political shadow haunted reformers for another fifteen years."[39] Following the Labour government's defeat in 1975, reform of the health system was

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[34]This is a direct quote from the Department of Health's 1974 annual report. Cited in Derek Dow, *Safeguarding The Public Health: A History of the New Zealand Department of Health*, Wellington: Victoria University Press, 1995, p. 214.

[35]Geoff Fougere, "From Market to Welfare State? State Interventions and Medical Care Delivery in New Zealand" in C. Wilkes and I. Shirley (eds), *In The Public Interest*, Auckland: Benton Ross, 1984, p. 83.

[36]In the longer term, it was envisaged that the role of the Regional Health Authorities would extend to primary care through centrally funded health benefits Source: Miriam Laugesen and George Salmond, "New Zealand Health Care: A Background", *Health Policy*, vol. 29, 1994, p.15.

[37]New Zealand Medical Journal, Editorial, "Solidarity", vol. 81, 11 June 1975, p. 525.

[38]Iain Hay, *The Caring Commodity: The Provision of Health Care in New Zealand*, Auckland: Oxford University Press, 1989.

[39]Martin, "Devolution and Decentralisation", op. cit., p. 278.

seen as electoral folly, and successive governments moved with "glacial slowness" in the area of health sector reform.[40] In spite of this, change did occur as the new National government recognised the growing urgency of the health system's problems. However, the government adopted a more consultative approach than its predecessor, and established the Special Advisory Committee on Health Services Organisation (SACHSO). Sensitive to the pressure for a more integrated system, the final proposals of SACHSO were very similar to those of *A Health Service for New Zealand*, but centred around the formation of Area Health Boards. Area Health Boards were designed to synthesise both hospital and public health services at the local level by amalgamating the functions of the Hospital Boards and the Department of Health's district health offices into one regional body. By creating one administrative body to plan and co-ordinate health services in the public, private and voluntary spheres, it was hoped that the duplication and fragmentation in the provision of services that was believed to exist under the Hospital Board system would be significantly reduced. It was also hoped that by having just one body, services would be rationalised and could be delivered for the same amount of money or less, hence improving efficiency in the system.[41]

The government was unwilling to impose the concept of Area Health Boards on Hospital Boards, and instead trialed them under two pilot schemes in Northland and Wellington until 1981. Although these schemes did not replace the existing structures but operated alongside them, they were considered a success, and the Area Health Board concept

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[40]Geoff Fougere, "The State and Health Care Reform" in Andrew Sharp (ed), *Leap Into The Dark: The Changing Role of the State in New Zealand Since 1984*, Auckland: Auckland University Press, 1994, p.110.
[41]Gordon Davies, "New Zealand Health Care: From Ossification to Action", *Journal of Health Administration Education*, vol. 8, no. 3, 1990, p. 377.

was formally endorsed in legislation in 1983. In spite of this success, the political sensitivity of the reorganisation of health services meant it was largely left to the Hospital Boards to initiate the transfer to Area Health Boards. On the whole, Boards were slow to make this transition, and it was only in 1989, with the appointment of Helen Clark as Minister of Health, that the transition to Area Health Boards was finally completed.

During the early 1980s a second effort was also made to improve the efficiency of the health system, and this was the shift to a population based funding formula (PBFF) to finance Hospital Boards.[42] In the early 1980s, Treasury began to place funding restrictions on Vote:Health as the commitment to providing unlimited resources embodied in the 1938 Social Security Act became unsustainable.[43] In light of this pressure, increased attention began to be focused on hospital spending, as this alone was responsible for consuming nearly 70% of Vote:Health. Spending on hospitals was also an area of concern because significant inequities existed in the wealth of Boards and in the type and quality of services they offered. These inequities largely stemmed from the funding mechanism that was used to finance Hospital Boards. At that time, Boards were funded according to their previous year's entitlement, along with adjustments for wage and price increases, the construction of new buildings, and general growth. Unfortunately, the result was a system that was highly politicised, with politically skilled Boards being able to win funding increases at the expense of less proficient Boards.[44]

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[42]For a more detailed account of this funding formula', see Advisory Committee on Hospital Board Funding, *The Equitable Distribution of Finance to Hospital Boards*, Wellington: Government Printer, 1980, and later, A. G. Smith and F. M. Sutton, *The Hospital Funding Formula* Blue Book Series 19, Wellington: Department of Health, 1984.

[43]Dow, *Safeguarding The Public Health*, op. cit., p. 220.

[44]Davies, "New Zealand Health Care: From Ossification to Action", op. cit., pp. 375-377.

A further weakness of this method for allocating resources was that it did not take into account the need to make changes in the level of funding to Boards to compensate for changes in the population. As the population in the North Island, and particularly Auckland rose, but the population in the South Island remained static, this placed severe funding pressure on Auckland. As a result, in 1983 the National government moved to a population based funding formula to finance public hospitals.

The PBFF was a complicated formula that was designed to provide a technical solution for the difficult and very political question of how to distribute resources equitably. Although the formula was clearly aimed at allowing central government greater control over the amount of funding Hospital Boards received, it was also attractive to Boards because it allowed them much greater control over how they used their entitlement.[45] However, it was still very difficult to reduce funding to hospital boards because Boards threatened with cutbacks were able to voice their concerns, and the resulting publicity usually prevented the reductions from occurring.[46] In spite of this, the introduction of the PBFF did result in the per capita funding for hospitals remaining virtually constant over the next decade.[47]

In 1984 the National government was defeated. The new Labour government immediately embarked on a program of sweeping reform necessitated by a severe fiscal crisis, and an urgent need to improve the country's economic performance which had stagnated under the policies

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[45]Fougere, "From Market to Welfare State?" op. cit., pp. 83-84.
[46]Davies, "New Zealand Health Care: From Ossification to Action", op. cit., pp. 375-377.
[47]Fougere, "The State and Health Care Reform", op. cit., p. 109.

of the previous National government.[48] The architects of this reform were Labour's Minister of Finance Roger Douglas and Treasury. For the health sector, this marked the beginning of the rise of the corporate rationalisers, and their arguments that the system was beset with provider and community 'capture'. The 1984 post election briefing document produced by Treasury commented on "underlying deficiencies"[49] in the structure of the health system, arguing that resources were not always being used to their fullest.[50] More specifically, Treasury analysts commented on the phenomenon of 'provider capture' in health.[51] These analysts argued that spending on community health care, which was cited as having the potential to be a better form of treatment than the use of larger institutions, had not increased, and that this failure may have been due to physicians acting to favour their interests rather than those of their consumers:

> . . . this failure to shift resources to areas of higher potential benefits may reflect the orientation of health services to the preferences of suppliers, rather than to the preferences of their clients.[52]

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[48]There is a wealth of literature on this reform. Interested readers should see, among others, Alan Bollard and Robert Buckle (eds), *Economic Liberalisation in New Zealand*, Wellington: Allen and Unwin, 1987; Jonathon Boston and Martin Holland (eds), *The Fourth Labour Government*, Auckland: Oxford University Press, 1987; Brian Easton (ed), *The Making of Rogernomics*, op. cit.; Margaret Wilson, *Labour in Government 1984-1987*, Wellington: Allen and Unwin, 1989.

[49]New Zealand Treasury, *Economic Management*, Wellington: Treasury, 1984, p. 270.

[50]The post election briefing document argued this was due to two factors. First, the 'free' provision of health care to consumers removed the role of price signals that would otherwise ensure that the quality and volume of services delivered reflected their cost. Second, providing services through government-funded institutions reduced the incentive for suppliers to provide those services at least cost. Source: New Zealand Treasury, *Economic Management*, op. cit., p. 271.

[51]'Middle class capture' and 'provider capture' are often used to indicate connected occurrences. Provider capture is the situation "where those who supply state-provided services pursue their own interests at the expense of the interests of consumers." The medical profession is often targeted as an example of provider capture because of the high costs to enter the profession, and the significant barriers that are imposed on unlicensed practitioners. Although these restrictions are cited as necessary to maintain a high standard of professional care, they also generate benefits which physicians are able to appropriate for personal gain. This privileged position also allows physicians to pursue their own interests such as acquiring high cost technologies, and favouring middle class clients with whom they share a cultural and behavioural affinity at the expense of lower class patients. Source: Geoff Bertram, "Middle Class Capture: A Brief Survey", in Royal Commission on Social Policy, *April Report*, Vol. II, Part 2, Wellington: Government Printer, 1988, pp. 109-170.

[52]New Zealand Treasury, *Economic Management*, op. cit., p.272.

However, the government's attention was not on health, but on introducing a variety of measures to liberalise the economy, and increase efficiency in all sectors of government activity. These included the introduction of private sector management and accounting practices into the public sector, the deregulation of many industries, including banking, finance, transport, telecommunications and broadcasting, and the transformation of government departments with commercial value into profit generating State Owned Enterprises (SOEs). Many of these were later fully or partially privatised, and sold to overseas buyers.[53] The heavy emphasis on greater efficiency that was present in the public sector was also spilling over into health. The amount of funding being spent on health was increasing, but the government was beginning to question more closely the benefits of these increases. Prompted by a fall in the real value of the General Medical Services benefit, and an acute conflict between doctors and the Minister of Health over 'free' visits for children, the Government initiated a review of the health sector in 1986.

This review was to examine the existing system of health care benefits, but its terms of reference also included reporting on the "underlying rationale for state involvement in health and to recommend broad principles and directions for reform."[54] The report, *Choices for Healthcare*, noted areas of concern within the health sector such as perverse incentives for surgeons to work in the private and public sector, confused accountability, lack of adequate information on the costs and effectiveness of services provided by hospitals, and insufficient responsiveness to the needs of many consumers of health services. The

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[53]Kelsey, *The New Zealand Experiment*, op. cit., pp. 3-4.

[54]Claudia Scott, Geoff Fougere, and John Marwick, *Choices For Health Care: Report of the Health Benefits Review*, Wellington: Government Printer, 1986, p. 1.

report proposed five broad structural options for the health care system, but expressed a preference for Option 4(b) which retained the state as the dominant funder of health services but introduced more contestability into the provision of services. In this option, the report envisaged a system where Area Health Boards would determine the range of services to be provided for their populations through research and discussions with communities and providers, and would then put these services out for tender and award contracts on the basis of quality and price.[55] It was argued that this system would be more accountable, encourage better use of resources, and be more responsive to consumers. Changes to equity and efficiency, however, would depend on the details of the contracts between boards and providers.[56]

Although the proposals recommended by the review team were never implemented, the drive to improve the efficiency of the health sector by the corporate rationalisers was growing stronger. Both Roger Douglas and Treasury were concerned about the amount of money the health system was continuing to consume, and this led to a second review of the sector in 1987, to be chaired by Alan Gibbs. Gibbs was "a private sector whiz-kid" who had chaired the board of Forestcorp, and had been responsible for radical restructuring that resulted in massive job losses.[57] His chairmanship was extremely significant not only because he was a clear advocate of privatisation but because his appointment fuelled concern in the health sector that the review's agenda was one of privatisation. Even before its release, the work of the Hospital and Related Services Taskforce was to prove highly controversial. Material was leaked to the media which suggested the Taskforce was exploring the

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[55]Ibid, p. 111.
[56]Ibid, p. 112.
[57]Interview, Former Canterbury Area Health Board member, 2 May 1996.

possibility of privatising the health system, and Gibbs has since stated, "[t]he model we came up with . . . was only a transitional step to people purchasing their own health services paid for from tax cuts. In the long run I foresaw hospitals being privatised."[58]

Not surprisingly, on its release the report of the Taskforce, commonly referred to as the Gibbs report, was highly critical of the public hospital system.[59] It claimed the system was inflexible, unresponsive and inefficient, and cited the lengthening waiting lists and low morale as key areas of concern. The report also strongly criticised the triumvirate system of management as being "over-centralised, bureaucratic, inflexible and confused," which produced stifled leadership and diluted accountability.[60] Furthermore, it condemned the lack of adequate management information in the system, and claimed it produced a lack of cost consciousness which undermined the efficient allocation of resources in the hospital system.[61]

The report also claimed inefficiencies in the sector were a product of 'provider capture'. This was extremely important because the prominence given to provider capture in the Gibbs report reinforced the government's perception that this was a structural flaw of the health system. Hospital and Area Health Boards felt a loyalty to their staff which meant they could not always make efficiency gains, and services were often oriented more to the needs of providers than consumers. This was most clearly reflected in the high percentage of resources that were

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[58]David McLoughlin, "How Bad is Our Health System? Is New Zealand's Number One Concern Beyond Solving?", *North and South*, Issue 126, September 1996, p. 74.
[59]Alan Gibbs, Dorothy Fraser and John Scott, *Unshackling the Hospitals: Report of the Hospitals and Related Services Taskforce*, Wellington: Government Printer, 1988.
[60]Ibid, pp. 18-19.
[61]Ibid, p. 21.

commanded by hospitals, which favoured clinicians, but often came at the expense of community based programs. This perception of provider capture was also reinforced by a survey released at the same time which found approximately two thirds of Hospital board positions were occupied either by doctors, or by the spouses or relatives of medical professionals.[62]

The report addressed these problems by proposing:

> a structure which retains government as the main funder and provider, but introduces a clear separation between the two roles. This separation enables a market to be created in which prices are set by modified competition between hospitals.[63]

These proposals entailed the creation of six regional health authorities to be responsible for determining the health needs of their populations, and purchasing health services through contracts with public, private and voluntary organisations. These regional health authorities would not own any services, but would instead contract with providers on a "competitively neutral basis," and would award contracts according to quality and value for money.[64] Public hospitals would become independent and separate business units, and Area Health Boards would become more like "the boards of public companies" who "would be able to concentrate on running efficient services."[65] As a result, the report argued the new structure would "unshackle" the organisations responsible for providing health services from bureaucratic control, and

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[62]Simon Ferguson, *The Inconvenient Realities of Health Reform*, Unpublished MA Thesis, University of Auckland, 1995, p. 88.
[63]Gibbs et. al., *Unshackling the Hospitals*, op. cit., p. 26.
[64]Ibid, p.27.
[65]Ibid, p. 28.

would "raise the levels of efficiency, responsiveness and accountability. . . while also improving access and morale" in the system.[66]

Yet the idea of a market in health was not new, as it had been clearly stated in Treasury's post election briefing to the government in 1987:

> So long as the state is a major purchaser of health care there seem to be advantages in separating the purchase of health care from the production of hospital or other services. The present amalgamation of functions causes confusion of roles. Equity goals and efficiency targets are forever entangled.[67]

Instead, the biggest impact of the Gibbs report came from the efficiency savings cited in the Arthur Anderson report, and the corresponding prominence they gave to the idea of market disciplines operating in health. Accompanying the Gibbs report was an independent study completed by the international firm Arthur Anderson on the efficiency of the hospital sector.[68] In this report, the Arthur Anderson analysts claimed that huge savings of between 24 and 32 per cent of the operating expenditure, or approximately $450 to $600 million, could be made in the hospital sector.[69] These figures were then used to underpin the Gibbs Report's prescription for reform. Yet this claim was made with data that the report had openly acknowledged as being completely inadequate. Consequently, the claim was strongly criticised by opponents of the report, who correctly argued that its methodology was severely flawed.[70] Nonetheless, these claims were frequently repeated by

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[66]Ibid, p.3 and 27.

[67]New Zealand Treasury, *Government Management*, Wellington: Government Printer, 1987, p. 159.

[68]Arthur Anderson and Co., *Hospital Performance Assessment Review*, Wellington: Department of Health, 1987.

[69]Gibbs et. al., *Unshackling the Hospitals*, op. cit., p. 13.

[70]Due to an absence of the appropriate data on New Zealand hospitals, the report used comparisons of resources of what were argued to be comparable services. The savings were then determined by "assigning to all hospitals the lowest level of costs estimated for a service in the study and subtracting this from the estimate of current actual costs". Source: Geoff Fougere, "Health Policy and the Gibbs Report: An

Alan Gibbs in the media, and gave considerable publicity to the ideas and philosophy of the corporate rationalisers. However, these predictions not only fuelled expectations in the system as to what efficiency gains were possible, but they would persist in the sector, significantly influencing later efforts at reform.

The Gibbs report is extremely significant because it marks the evolution of the corporate rationalisers into market rationalisers. The goals of efficiency, cost consciousness and co-ordination idealised by the corporate rationalisers are clearly expressed in the Gibbs Report. In contrast to the 1974 *A Health Service for New Zealand*, the means of achieving these goals had changed from the command and control bureaucratic structure to a market, or quasi-market, mechanism.

It soon became clear that the government was not going to implement the proposals of the Gibbs Report. This was largely due to strong resistance from doctors who opposed the level of competition contained in the report, and by the change in Minister of Health from Michael Bassett to David Caygill. Neither David Caygill nor his successor Helen Clark saw the Gibbs report as an appropriate direction for reform. In spite of the government's rejection of the Gibbs Report, however, change continued to occur in the sector. Helen Clark focused on strengthening government's influence on the spending decisions of the Area Health Boards. This involved reducing the number of elected members and replacing them with appointed members, introducing a contract system between the Ministry of Health and the Area Health Boards, and development of the New Zealand Health Charter and New Zealand Health Goals and Targets to set joint objectives for Boards to achieve.

Analysis", Paper presented at the New Zealand Sociology Association Conference, 26-28 August, 1988, p. 4.

These measures were also complemented by the State Sector Act (1988) which saw the introduction of general management into Area Health Boards. Subsequently, by the end of the decade, many Boards were beginning to operate in a more business-like manner, and were achieving productivity improvements.[71]

Helen Clark also continued the trend begun by Michael Bassett to use independent consultants rather than advice from the medical community. In essence, this trend was in response to concerns over provider capture. Prior to the mid 1980s, physicians were the dominant voice advising governments on the direction of health policy, but because physicians were perceived to have vested interests in the way health services were provided, they became seen as an inappropriate source of policy advice. As a result, international and domestic companies such as Arthur Anderson, Coopers and Lybrand, and CS First Boston Ltd were called upon to write reviews of the health sector, and to develop solutions for reform.[72] However, many of these companies perceived the problems and solutions of the health sector in the same light as Treasury. Consequently, although the use of these companies gives the appearance of allowing previously unheard voices to comment on and influence health policy, these consultants were used by Treasury and Ministers largely to give legitimacy to points of view already promoted in the health sector.[73]

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[71]Toni Ashton, "Reform of the Health Services: Weighing Up the Costs and Benefits" in Jonathon Boston and Paul Dalziel (eds), *The Decent Society? Essays in Response to National's Economic and Social Policies*, Auckland: Oxford University Press, 1992, p.150.

[72]Robert Blank, *New Zealand Health Policy*, Auckland: Oxford University Press, 1994. For more detail on the use and costs of these consultants see James Conner, *The Political Economy of Health Care in New Zealand: A Comparative Analysis*, Unpublished PhD Thesis, Christchurch: University of Canterbury, 1995.

[73]See, for example, Jane Kelsey, *The New Zealand Experiment*, op. cit.; Brian Easton, "How Did the Health Reforms Blitzkrieg Fail?", *Political Science*, vol. 46, no. 2, 1994, pp. 215-233; Joe Atkinson, "Health Reform and 'Thin' Democracy", *Political Science*, vol. 46, no. 2, 1994, pp. 193-214; Simon Ferguson, *The Inconvenient Realities of Health Reform*, op. cit.

However, 1990 was an election year, and the resulting loss by the Labour government indicated that some sections of New Zealand society had clearly had enough of the rapid, far-reaching reform which had occurred over the last six years. The National party had campaigned on the basis that it would not introduce further radical change to the health sector, but when it took office, it embarked on a program of even further reform, necessitated initially by the presence of a fiscal crisis that developed after the election.[74] The government claimed the urgency and unexpected nature of this crisis necessitated a program of "stiff medicine" to bring the country back to economic prosperity, and National needed to abandon many of its election promises and introduce drastic cuts to government spending, especially in the area of welfare.[75]

In this package, the National government also announced the creation of a Health Services Taskforce to "identify and investigate the roles of Government, the private sector, and individuals in the funding, provision and regulation of health services."[76] The terms of reference for the Taskforce, however, clearly reflected the strong market orientation of the new Government. Specifically, they referred to the need for the greater targeting of assistance, more individual responsibility in the provision of health services, and the necessity of competition to improve efficiency within the sector. The Government wanted the Taskforce to analyse the existing reviews of the health sector, in conjunction with international experience, and develop a

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74 For a discussion of the existence of the fiscal crisis in 1990, see Paul Dalziel, "National's Economic Strategy" in Jonathon Boston and Paul Dalziel (eds), *The Decent Society? Essays In Response to National's Economic and Social Policies*, Auckland: Oxford University Press, 1992.

75 James Bolger, Ruth Richardson and William Birch, *Economic and Social Initiative - December 1990*, Statements to the House of Representatives, Wellington: New Zealand Government, 1990, p.3.

76 Ibid, p.75.

solution which would be appropriate for New Zealand society.[77] The Taskforce completed its work shortly before the Budget was announced, but its findings were never released to the public. Hence, it can only be assumed that the Taskforce's conclusions supported the recommendation of the Treasury and the Gibbs Report to introduce competition into the health sector by separating the purchasing from the provision of health services.[78]

The shape of the reformed health system was finally revealed with the government's first budget on 30 July 1991, in a report entitled *Your Health and the Public Health*, which also became known as the Green and White Paper.[79] As had been reiterated in Treasury's post election briefing document, the reforms were an attempt to confront the perceived problems of the health sector by radically redesigning its institutional structure. By separating the purchasing of health services from their provision, the 'market rationalisers' sought to privilege their interests above those of providers and communities, and so create the conditions in which efficiencies would be 'ground out' of the system.[80]

The existence of a fiscal crisis was again used to justify the scale of the reforms, with the country's poor economic performance and high levels

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[77]Simon Upton, *Your Health and the Public Health*, Wellington: Government Printer, 1991, p. 10.

[78]At the same time as the Taskforce was in operation, the Business Roundtable commissioned a report by Patricia Danzon, a visiting professor from CS First Boston. The report described how a publicly funded health system could be transformed into a privatised system, but it was influential only to the degree that it worked out in practice ideas that were already being independently developed by Treasury and the Taskforce. See Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand*, Wellington: CS First Boston, 1991.

[79]Simon Upton, *Your Health and the Public Health*, Wellington: Government Printer, 1991.

[80]See among others, Simon Upton, *Your Health and the Public Health*, op. cit.; Geoff Fougere, "The State and Health Care Reform", op. cit.; Brian Easton, "How Did the Health Reform Blitzkrieg Fail?", op. cit.; Toni Ashton, "Reform of the Health Services: Weighing Up the Costs and Benefits", op. cit.; Pim Borren and Alan Maynard, *Searching for the Holy Grail in the Antipodes: The Market Reform of the New Zealand Health Care System*, York: Centre for Health Economics, 1993; Philippa Howden-Chapman, "Doing the Splits: Contracting Issues in the New Zealand Health Service", *Health Policy*, vol. 24, 1993, pp. 273-286; Claudia Scott, "Reform of the New Zealand Health Care System", *Health Policy*, vol. 29, 1993, pp. 25-40.

of overseas debt being cited as key factors in the need for reform. In particular, these factors meant the government could no longer afford to fund the open ended commitment to health services of the 1938 Social Security Act, and instead needed to limit its liability and shift the costs of providing health services back to individuals and families.[81] The proposals for reform could also be understood as laying the foundations for the eventual privatisation of the health system, so creating the means by which the state would be able to exit from the provision of health services.

The government argued that the current health system was "structurally flawed," and unable to "deliver accessible and affordable care to New Zealanders in the future."[82] However, as the Area Health Board system was not fully operational until 1989, many commentators argued the system had not been in existence long enough to justify this claim. Area Health Boards had been introducing measures to improve efficiency, and were working towards a "delivery system which more closely resembled the business practices of private enterprise."[83] However, some Area Health Boards, particularly Wellington and Auckland, were having significant difficulties, and their difficulties appeared to typify what the reformers considered was wrong about the Area Health Board system.

The architects of the reforms argued that significant institutional reform was required as Area Health Boards suffered from a number of structural difficulties that prevented them from operating effectively.

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[81]Upton, *Your Health and the Public Health*, op. cit., p. 1.

[82]Ibid, p.9.

[83]Examples of these measures include the introduction of general management and service management into the Boards, the installation of computerised information systems, the development of performance indicators, and the preparation of business plans by Area Health Boards. Source: Toni Ashton, "Reform of the Health Services", op. cit., p. 150.

First, Area Health Boards were perceived to have conflicting roles as the purchaser and provider of services. This meant Boards had strong incentives to purchase their own services even when other more efficient and appropriate providers were available, particularly as contracting out to other suppliers could result in the loss of jobs for Board staff, and Board facilities being underutilised. Area Health Boards were also seen to be operating in a policy framework that placed too many constraints on the way they used their resources and offered only weak incentives for them to use their resources efficiently.[84] As a result, Boards tended to reduce costs through cutting services, and these reductions were often made to 'Cinderella' services, such as mental health.

These cuts to services were also exacerbated by the dual accountability of Area Health Boards. Elected Boards were seen to be accountable to both their local constituents and the Minister of Health, but whereas they were seen to have strong responsibilities to the communities which elected them, they were perceived to have little responsibility for the funding they received.[85] Consequently, when Boards wanted to reduce services or make changes to the delivery of a particular service, they would often experience intense public opposition that would effectively hamper their ability to implement that change. The Green and White Paper argued that this "politicisation of the decision-making process" encouraged Boards to shift the responsibility onto government through claiming a lack of funding instead of attempting to improve their own efficiency.[86] Furthermore, as Boards received funding from government regardless of their performance, inefficient Boards could argue for

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[84]Simon Upton, *Your Health and the Public Health*, op. cit., pp. 23-26.

[85]For a discussion of the accountability of Area Health Boards, see John Martin, "Devolution and Accountability: Governance in the Health Service", *NZ Health Review*, vol. 9, no. 1, 1989, pp. 7-12

[86]Upton, *Your Health and the Public Health*, op. cit., p. 9.

more funding if services were threatened, hence perpetuating the wastage of resources.

'Provider capture' was again identified as a major impediment to the efficiency and responsiveness of the system. The Green and White Paper argued Area Health Boards were subject to provider capture because the Boards tended to favour hospital based services. Not only did this concentration on hospitals advantage clinicians, but it meant there was "little incentive to move to community, day-stay or outpatient care, even where this would serve patients better and offer greater value for money."[87] Hence, Area Health Boards were criticised for not being sufficiently responsive to consumers' changing needs, and for perpetuating the focus on the 'bricks and mortar' of health services.

In addition, the system was also criticised on a number of other grounds. Waiting lists were perceived as being too high, and there was a lack of sufficient management information, especially on the costs of services. The fragmented funding for primary, secondary and accident care, and the poor integration between these sectors, were also targeted as key problem areas, with the Green and White Paper claiming "no one agency has responsibility for ensuring that a person's care is well managed, or meets their needs in adequately in a cost-effective way."[88] As such, the system suffered from duplication of services, and poor communication and co-ordination, with consumers at risk of "falling between the cracks."[89]

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[87] Ibid, p. 13.
[88] Ibid, p.42.
[89] Ibid.

In response to these perceived failings, the government argued that radical reform of the health system was needed; reform that embodied a separation of the purchaser from the provider. To this effect, Area Health Boards were immediately dis-established, with Commissioners being appointed to oversee their functions until the reforms came into effect in July 1993. Their functions would then be the responsibility of two new organisations, Regional Health Authorities and Crown Health Enterprises. On the purchasing side, four RHAs would be established to be responsible for the purchase of all publicly funded health and disability support services for their respective populations.[90] They would purchase both primary and secondary care, and would do this through contracting with competing public, private, and voluntary agencies. They would be funded through the Ministry of Health, and would be governed by an appointed Board of directors instead of elected officials. RHAs were required only to consult with communities over the range of services to be provided in their localities. With the loss of direct, elected representation, this was a substantial loss of power for local communities.[91]

Secondly, the way in which health services would be provided was reorganised. Public hospitals were reshaped along commercial lines to become Crown Health Enterprises. Unlike Area Health Boards, CHEs were to "operate on a business-like basis," and were to make a return for their shareholding Ministers.[92] Their funding would be directly related to their ability to compete with other public, private and voluntary

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[90]Initially, the government intended to create competition for the RHAs through the establishment of Health Care Plans (HCPs), but in response to public opposition and administrative difficulties, the HCPs were indefinitely delayed.

[91]See George Salmond, "A Community Left Behind" in Lyndon Keene (ed), *Health Reforms: A Second Opinion*, Wellington: Wellington Health Action Committee, 1992, p. 11, and John Martin, "The Case for Local Voice" in Lyndon Keene (ed), *Health Reforms: A Second Opinion*, Wellington: Wellington Health Action Committee, 1991, p. 22.

[92]Upton, *Your Health and the Public Health*, op. cit., p. 35.

providers for RHA contracts. Where it was not suitable for smaller hospitals to become CHEs, local communities were given the option of assuming ownership of their local facilities as Community Trusts (CTs). This option was subject to government approval and economic viability. While it allowed communities more involvement in the provision of health services to their area, these trusts would be dependent on their ability to successfully negotiate contracts for their funding.[93]

In separating the purchasing role from the provider, the government sought to create a competitive, 'quasi-market' in which RHAs would purchase services for their local populations from competing providers. It was assumed the establishment of competing providers would place pressure on these organisations to deliver the most efficient forms of health service for a given quality. This would then lead to a system which would allow "more people [to be] treated with the same or better quality of service, for the same amount of money."[94] Its designers also intended it to stimulate innovative ways of delivering health care, and to promote greater flexibility within the health system, thus better equipping it to adjust to the changing demands of consumers.[95]

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[93]In addition to these steps, the government also implemented changes to the system of user part charges, and established a National Advisory Committee on Core Health and Disability Services to develop a list of "core services". Core services would be services that "everyone should have access [to] on affordable terms and without unreasonable waiting time." See Upton, op cit, p. 75. RHAs and Healthcare Plans would be required to purchase this list of services, and the government would assist all consumers to obtain these services. The government contended the concept of core services would not only allow the government to limit its obligations to provide access to health services, but it would also facilitate better rationing of scarce resources and control the growth of medical expenditure. In addition to these steps, the government established a Public Health Commission (PHC) to assume responsibility for the provision of public health services, and indicated its intention to review the means by which the health system was financed. The PHC was later reintegrated back into the Ministry of Health, and the government decided to retain a tax based system of financing the health system as a result of public opposition and enormous practical difficulties in the alternative schemes.

[94]Ibid, p. 37.

[95]Fougere, "The State and Health Care Reform", op. cit., p. 113.

Although these goals are in the public's interest if they improve the delivery of health services, it is also evident that quite apart from the stated aims, the National government's health reforms sought to implement an institutional structure that would privilege the fiscal agendas of central government. In theory, this new institutional structure would insulate the RHAs "from those [interests] seen to have 'captured' the old system," so that the RHAs could make the difficult rationing decisions that Area Health Boards were seen to be incapable of.[96] The dominance of providers was weakened by shifting the initiative for deciding what services should be delivered from providers, notably doctors, to purchasing agencies. By making RHAs responsible for determining the range of services to be purchased, and then contracting those services out to competing providers, RHAs would have strategic control over what health services would be available. Moreover, providers would be held at arm's length through the process of formal contracting. Local communities no longer had direct, elected representation on the governing Boards of the RHAs and CHEs, leaving only the requirement for consultation.

Conclusions

In New Zealand, reform of the health system has been part of a wider, ideologically driven process of reform. The steady rise in prominence of the New Right, has brought massive amounts of change to virtually all sectors of New Zealand society, often within short time-frames, and at a high social cost. However, this change has been possible because it has occurred in a political system that Immergut would classify as having a minimum of veto points. New Zealand's very centralised system of

[96]Fougere, "What is the Core Business of Vote:Health?" op. cit., p.21.

policy making, with its extremely powerful executive, and few constitutional checks and balances offered the ideal arena in which the market rationalisers could impose their ideology on the health sector.

The shape of the health reforms in 1991 represented a great success for the 'market rationalisers', and their principal agents, Treasury. Significantly, the implementation of a 'managed market' meant that Treasury was no longer influencing just the size of the health budget, but had become a key actor in determining the actual arrangement of the sector. In the designing the new institutional arrangements, the market rationalisers had sought to eliminate the veto points that Immergut would argue allowed providers and communities to have control over resource decisions, and had also introduced new purchasing interests that would further undermine the power of communities and providers. Although this system gave the appearance of placing the government in a stronger position to impose its interests on the system, the realities of implementing such a controversial and unpopular system would soon undermine the government's institutional strength.

Chapter Four: Implementation of the Reforms: the Transition to RHAs and CHEs

Introduction

After the release of the Green and White paper, the government's next challenge was the implementation of the reforms. The government sought to complete the transformation to the new system as quickly as possible, but soon discovered that the implementation process would be far from smooth. The influence of the market rationalisers was maintained in the implementation process, as new organisations were created to establish the RHAs and CHEs which employed key figures from Treasury and the private sector.[1] However, this recruitment of prominent people from the private sector with business rather than health expertise only fuelled public fear over the purpose of the reforms, and created an increasingly hostile environment for a government seeking re-election. As the ideology of the reforms foundered in the wake of this public opposition, the government was forced to modify and withdraw the more controversial aspects of the reforms. For rural hospitals, the implementation of the reforms brought heightened vulnerability. Although the roll over of services required in the first year of the reforms gave the hospitals a small measure of security, this was offset by the troubled financial position of the CHEs. With the retention of debt from the Area Health Boards, and high operating deficits, CHEs had strong incentives to make efficiency gains through the closure of rural hospitals.

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[1] For more development of this, see Brian Easton, "Why Did the Health Reforms Blitzkrieg Fail?", op. cit., and Joe Atkinson, "Health Reforms and 'Thin' Democracy", op. cit.

The Establishment of the RHAs and CHEs

The proposals to reform the health system as foreshadowed in 1990 were officially announced as part of the National government's budget in July 1991.[2] Due to the lack of consultation in the development of the reforms,[3] the public was largely unprepared for their strong commercial emphasis, and reacted with a mixture of surprise, fear and suspicion. Some of this reaction was linked to the release of the reforms as part of a Budget specifically intended to redesign crucial parts of the welfare system, and to change the public's attitude about the role of the state in the provision of welfare services. The Budget included such measures as a reduction in the levels of virtually all social welfare benefits, with greater targeting and means testing of benefits, the retention and increase of the unpopular national superannuation surcharge, and changes to the payment of compensation for accident victims. Clearly, the Budget's aim was to reduce the government's expenditure on welfare, and to encourage the provision of welfare services as a responsibility of individuals and families rather than the state. The coupling of the health reforms with the Budget suggested to many that the proposed restructuring of the health sector was more concerned with allowing the government to reduce its expenditure and involvement in health rather than creating a better health system.

Consequently, the release of the reforms with the Budget pushed to the limit the public's willingness to accept the health reforms as necessary

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[2]For an analysis of this Budget, see Jonathon Boston and Paul Dalziel (eds), *The Decent Society?*, Auckland: Oxford University Press, 1992.

[3]Atkinson, "Health Reforms and 'Thin' Democracy", op. cit. p. 195, and Alan Gray, "Good Health Care is Everybody's Business" in *Health Reforms: A Second Opinion*, Wellington: Wellington Health Action Committee, 1992, p. 12.

and beneficial. The sheer magnitude and scope of the reforms meant they would have been difficult to accept at any time, but they were even more so in a context of sweeping reform to a welfare system that had for so long been a source of national pride. This issue had been recognised by the public relations firm Logos hired by the government to make the Budget more attractive to the public. Accordingly, Logos specifically recommended launching the health reforms before the Budget to separate the two, and to prevent the complexity of the health reforms detracting from the overall message of the Budget. In the "messy last-minute scramble"[4] before the release of the Budget, however, this recommendation was not followed by the government, and as a result, the launch of the health reforms was a "political and public relations fiasco."[5]

In Canterbury, for example, rural communities reacted with shock at the announcement of the reforms. With the abolition of the Area Health Boards, the fragile security that each community had worked so hard to achieve for its hospital was destroyed. This created strong feelings of disappointment and frustration in these communities, which were exacerbated by the realisation that the issue would have to be renegotiated, but this time with new organisations likely to hold very different priorities from those of the Area Health Board.

However, the public's feelings of concern were considered less important by the government than the need to get the reform process under way. The government imposed a very tight deadline on the implementation of the health reforms, requiring them to be fully operational by 1 July

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[4]Atkinson, "Health Reforms and 'Thin' Democracy", op. cit., p. 198.
[5]Ibid.

1993, only two years after their announcement. This was in keeping with the trend of rapid policy implementation initiated under the Labour government and reflected the National government's concern with making the reforms operational before the general election in 1993. The presence of such powerful stakeholders in the health system as the medical profession, who had a history of successfully resisting previous government efforts at reform, as well as anticipation of the public discontent that the reforms were going to produce, created a sense of urgency for the government that the new structures be established as quickly as possible to ensure their survival.

Although the government had stated in the Green and White Paper that reform would be implemented in a "well-managed, co-ordinated, and timely way," their deadline made this commitment virtually impossible.[6] Constraints on time created the conditions in which hasty, and in hindsight unwise, decisions over the implementation of the reforms would be made.[7] This could initially be seen with the decision not to give the Department of Health responsibility for implementing the reforms. The Department was rejected because it was perceived to be dominated by 'vested interests' protective of the old system. Instead the Department was to administer the existing system, while a Health Reforms Group (HRG) was established in the Department of the Prime Minister and Cabinet (DPMC) to oversee the reform process.[8] The HRG formally encompassed the Health Reforms Directorate (HRD), which was responsible for creating the Regional Health Authorities; the National Interim Provider Board (NIPB), appointed to establish the

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[6]Upton, *Your Health and the Public Health*, op. cit., p. 127.

[7]For more development of this, again see, Brian Easton, "How Did The Health Reforms Blitzkrieg Fail?", op. cit., Joe Atkinson, "Health Reform and 'Thin' Democracy, op. cit., and Simon Ferguson, *The Inconvenient Realities of Health Reform*, op. cit.

[8]Atkinson, "Health Reforms and Thin Democracy", op. cit., p. 199.

providers, particularly Crown Health Enterprises; and the Communications and Co-ordination Unit (CCU), responsible for co-ordinating and communicating the reform process.[9] The HRG's placement with the DPMC was significant because it allowed the DPMC to maintain a close working relationship with Treasury, and for Treasury to have considerable oversight of the implementation of the reforms. As the HRG recruited staff from Treasury and from sources outside the health sector to occupy key positions within its ranks, this also strengthened Treasury's direct influence on the reform process.

The heavy reliance on personnel from outside the health sector to implement the reforms encouraged skilled health administrators to leave the sector. Their departure not only created a significant loss of expertise and 'corporate memory,' but, as Easton argues, meant that people with little experience in health administration were making critical decisions about how the reforms would operate in practice. In turn, this hampered the successful implementation of the reforms, for health presents its own set of unique difficulties which warrant specialised expertise.[10] The use of staff from Treasury and private sector businesses also opened the way for the reformers, and particularly the market rationalisers, "to impose their own vested interests on the sector," interests which in Easton's view could lead to the eventual privatisation of the system.[11]

The spectre of privatisation has been a recurrent theme which has dogged the health reforms. Although the chief aim of the health reforms was claimed to be the creation of a quasi-market where

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[9]Ibid.
[10]Easton, "How Did The Health Reforms Blitzkrieg Fail?", op. cit., p. 226.
[11]Ibid.

autonomous purchaser and provider organisations would have strong incentives to operate efficiently, and gain the maximum benefit from every Vote:Health dollar, this is only one of two frameworks in which the Green and White Paper can be understood. The Green and White Paper could be and was interpreted by many as introducing the structures which could lead to the eventual privatisation of the health system.[12] In the initial stages of the reforms, the appointment of high profile businessmen such as Sir Ronald Trotter and Dr Peter Troughton to control the provider side of the reforms fuelled public concern that the reforms would lead to the commercialisation of health, and the eventual privatisation of the system. Both Trotter and Troughton had backgrounds in restructuring and were strong advocates of privatisation, but they had no prior experience in health. Described as "can-do" men, Trotter and Troughton were careless of political processes, and held little regard for the need to build policy consensus or to generate public legitimacy.[13] Although the government argued they were involved because of their business expertise, their appointment to key positions within the reform structure created a strong link between business and health, and between those interests supportive of privatisation and the new provider organisations.

To initiate the provider side of the reforms, the government appointed Sir Ronald Trotter to lead the National Interim Provider Board (NIPB), and under his direction it worked very quickly. Continuing the

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[12]See among others, Brian Easton, "How Did The Health Reforms Blitzkrieg Fail?", op. cit.; Geoff Fougere, "Restructuring the Health Sector: Bringing Politics Back In", Discussant paper presented at Health Services Research Centre Conference: 'Emerging Themes in New Zealand Health Care' Wellington, 29 November 1994; Jane Kelsey, *The New Zealand Experiment*, op. cit.; R. Bowie and I. Shirley, "Political and Economic Perspectives on Recent Health Policy" in John Spicer, Andrew Trlin and Jo Ann Walton (eds), *Social Dimensions of Health and Disease: New Zealand Perspectives*, Palmerston North: Dunmore Press, 1994; Wellington Health Action Committee, *Health Reforms: A Second Opinion*, Wellington: Wellington Health Action Committee, 1992.

[13]Atkinson, "Health Reforms and 'Thin' Democracy", op. cit., pp. 204-205.

trend of using outside consultants, the NIPB commissioned a number of private consultancy firms, including CS First Boston, to report on various aspects of the Crown Health Enterprise concept, as well as the priorities of the NIPB.[14] Predictably, CS First Boston urged a strong commercial focus for the CHEs, and this was adopted by the NIPB. The NIPB released its findings in May 1992 in a report entitled *Providing Better Health Care for New Zealanders.*[15] In this report, the NIPB claimed that the previous system was beset by structural inadequacies and perverse incentives which meant increases in funding did not produce equivalent increases in output.[16] As a consequence, it recommended that CHEs should be formed along a businesslike, profit-making model, and be required to pay dividends to the government. Primarily, this was because the report contended that profit making organisations had "direct incentives to take an active and compelling interest in their business efficiency," and tended to be "better run, more flexible in their approach and noticeably more innovative" than non-profit making organisations.[17]

As in the Green and White Paper, competition was again heralded as crucial to the system, being cited as "the only way of ensuring, on a continuing basis, constant innovation and best value at optimum quality for every health dollar."[18] The NIPB believed there was ample scope for competition in the health sector, the sole exception being twenty four hour accident and emergency services which were identified as having

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[14]CS First Boston, *Identification of Tasks and Priorities for the National Interim Provider Board,* Report prepared for the National Interim Provider Board, Wellington: CS First Boston, 1991.

[15]National Interim Provider Board, *Providing Better Health Care for New Zealanders: Report to the Government and New Zealand Public*, Wellington: National Interim Provider Board, 1992.

[16]Specifically, the NIPB report claimed that in four years, Vote:Health was increased by 20 percent, and while not all of that money went to public hospitals, public hospital output rose by only 1.8 percent in real terms. National Interim Provider Board, *Providing Better Health Care for New Zealanders*, op. cit., p.6.

[17]Ibid., p. 38.

[18]Ibid., p.8.

only limited potential for competition. For the system to work effectively, however, the report argued that CHEs needed to be 'competitively neutral'. This not only involved "neutrality of funding," where RHA contracts would be awarded "irrespective of provider ownership" so as to encourage efficiency, responsiveness and innovation, but also "neutrality between alternative providers," where providers owned by the Crown would not have advantages over other providers in the competition for contracts.[19]

Competitive neutrality also involved CHEs retaining the debt incurred by Area Health Boards, although the report also acknowledged that there might be a need for the government to restructure some aspects of that debt to allow CHEs to be commercially viable. Moreover, the report advocated that the Crown might need to finance part of the CHEs' debt, but that this debt would be on "commercial terms," and would need to be refinanced "over a short period of years by direct borrowing from capital markets on a normal businesslike basis."[20]

For rural hospitals, one of the most significant aspects of the report was the argument for CHEs to be insulated from direct political influence. The NIPB believed that for CHEs to be commercially successful they needed the freedom to rationalise, lease or sell surplus assets without political pressure from politicians. Hence, the report advocated an "arm's length" relationship between the government and the managers of CHEs, and emphasised the importance of CHEs being sufficiently autonomous to make decisions on the effective use of resources, even when those decisions would be unpopular.[21] The report argued that any

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[19] Ibid., p. 54.
[20] Ibid., p. 62.
[21] Ibid., p. 11.

interference by politicians would only compromise the efficiency and competitiveness of the CHEs, and urged politicians to focus any concerns over equity or access on the RHAs, as the purchasers of health care. In the Chairman's foreword to the report, Sir Ronald Trotter claimed that Ministers "add most value when they deliberately limit their own role to setting the right goals, monitoring performance against those goals and holding boards strictly accountable for their performance."[22] He also warned that Ministers who did try to influence the resource decisions of CHEs could find themselves being held responsible for their actions and unable to hold the CHE boards accountable for the performance of the organisation.[23] Rather, accountability of CHE directors should centre around their ability to be "expeditiously replaced" if they failed to meet their objectives.

In October 1992, the NIPB was disbanded and replaced by the Crown Health Enterprise Establishment Unit (CHEEU), headed by Dr Peter Troughton. The CHEEU's task was to refine and implement the recommendations of the NIPB. To ensure adequate competition, the NIPB report had recommended that 20 to 25 Crown Health Enterprises be established, each located around one acute care hospital. The CHEEU accepted this, and appointed fourteen Crown Health Enterprise Advisory Committees (CHEACs) in each of the Area Health Board districts to advise on the number and configuration of the CHEs and possible community trusts. These committees comprised between five and six people, appointed principally for their commercial and financial expertise.

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[22]Ibid., p.8.
[23]Ibid., p.8.

In Christchurch, fierce debate erupted over the number of CHEs that should be created. Clinicians clearly favoured only one CHE, but other groups advocated more, arguing one CHE would be too large and cumbersome. Eventually, the issue was resolved with a decision to have two CHEs. These were divided so that one CHE, Canterbury Health, was responsible for all the acute secondary and tertiary services, general medicine, general surgery, and all of the specialities in medicine and surgery, while the second CHE, Healthlink South, would provide community based services, women, child and family health, elderly health, mental health, and some public health services. The Christchurch solution, however, was not adopted elsewhere.

Placement of the Rural Hospitals into the New Structure

It was only once this structure had been determined that the issue of the rural hospitals was addressed. After the boundaries of the CHEs and the RHAs were finalised, Canterbury was left with eight rural hospitals. The question of their long term position, however, was delayed because the CHEAC did not see them as an essential part of the CHE establishment process. As a member of the Canterbury CHEAC commented:

. . . it was what are we going to do with the big events, is it important to us to decide on the rural ones as part of that process, and the answer we had to that was no.[24]

To place the hospitals into this new structure, a one day workshop was conducted by CHEAC in mid 1992. Each hospital was represented by the principal nurse, the local GPs, the local mayor, and other relevant community members. At this meeting, each group was given the option

[24]Interview, Former CHEAC member, 25 May 1996.

of becoming a community trust, but this was unanimously rejected, and instead, all expressed a strong preference for being under the control of a CHE. The reasons behind this rejection are multifold. First, the representatives of each hospital felt that if they were to become a community trust, there would be greater potential for the hospital to close should the trust collapse. This was a very genuine concern, with each set of representatives voicing fears about the lack of surety in obtaining RHA contracts, the inability of the community to run the hospital without the support of a larger organisation, and the possibility of not having enough skilled community members willing to donate their time to run the trust. As one principal nurse commented:

. . . I felt very strongly that . . . our little hospital needed this umbrella of expertise provided by a large corporate outfit such as a CHE, and I truly felt that . . [we] needed the support of that conglomerate, of the big sister or brother thing, that we'd never cope without it.[25]

Consequently, they perceived the CHE as insulating them from these concerns, and as giving them a measure of security that they would not have as autonomous units.

After this decision had been taken, each set of representatives then worked through a process of examining the central issues for their hospitals, as they were defined by the CHEAC team. At the end of that process each group made a decision to go with the CHE that they felt had the closest links with the type of services their hospitals provided. As a result, Akaroa, Darfield, Ellesmere and Waikari chose to join Canterbury Health, because of their acute and recuperative care focus, while Lincoln, Rangiora, Kaikoura, and Oxford became part of

[25]Interview, Former Staff member Darfield Hospital, 26 April 1996.

Healthlink South because of the maternity and elderly services they provided.

However, this process to place the rural hospitals under the CHE structure was not viewed by all participants as being a genuine consultative exercise. Some of the principal nurses who were interviewed commented that they felt the issue of how to divide the hospitals between the two CHEs had been decided before the workshop was conducted, and that the equal division of the hospitals between the two CHEs was the best way to deal with what was seen by CHEAC as a difficult problem. As two principal nurses commented:

We were virtually pushed into it, the decision had been made and we had to be seen to be going along with it.[26]

I think a decision was made to split them up, four each CHE, and even though as nurse managers and GPs and other interested folk [we] were led to believe that the workshop we went to was to decide our futures and where did we feel we should sit, I think the decision had been made. Because during the day. . .we were actively encouraged to re-think. . . and I'm quite sure that politically, the four-four formula had been seen to be the probable answer, and yet a consultation process was gone through.[27]

This perception that the decision had been made prior to the workshop stemmed from a number of factors. First, the representatives believed that rural hospitals were seen in the post-reform era as being inefficient and anachronistic, and in conjunction with their small size, and recent government policy seeking to de-emphasise the focus on the 'bricks and mortar' of institutions, had a more symbolic than essential role. Consequently, this fostered a perception among the representatives of

[26]Interview, Principal nurse, 18 January 1996.
[27]Interview, Former Staff member Darfield Hospital, 26 April 1996.

the small hospitals that the decision was made before the workshop to divide the hospitals equally between the CHEs so as to evenly distribute their 'burden'.

This was strongly denied by a representative of CHEAC, who felt that perhaps a sense of the decision being pre-determined came about because the workshop was a very structured process. This process was designed to make the participants confront what CHEAC considered to be the relevant issues on the topic, and to make decisions based on the individual characteristics and needs of particular hospitals. As a member of CHEAC commented:

. . .there was a very deliberate attempt to have them go through confronting a series of issues. . .they were being forced to make decisions on the topic, rather than on a whole range of other issues, like which one had the biggest budget, who was going to give them the greatest assurances of future security . . .because [those were] not things that could be answered.[28]

These opposite accounts clearly indicate the different way rural hospitals at the periphery, and urban administrators from the centre, view the issue. From CHEAC's point of view, they had defined the most appropriate criteria in which the hospitals were to base their decision: the services the rural hospitals provided and the services that would be the responsibility of each CHE. As a member of CHEAC commented:

The issues that were critical . . . [were] for a particular CHE, was it most important that it had an interrelationship with an organisation that dealt with acute services, and recuperation from hospital operations and so forth, or was it more important to have had a closer relationship with an organisation that dealt with geriatrics and older people, or women's health and birthing.[29]

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[28]Interview, former CHEAC member, 25 May 1996.
[29]Interview, former CHEAC member, 25 May 1996.

For the representatives of the rural hospitals these criteria did not address their most pressing concerns. However, the key issues to which the rural hospitals wanted answers, such as which organisation would give them the best chance of survival, could not be answered. Therefore, although the representatives of the hospitals were apparently free to choose between the two CHEs, they were making a choice based on uncertainty and on a lack of knowledge about what to them were the critical questions.

By the conclusion of this process, the rural hospitals had been placed into the new CHE structure for Canterbury. This decision was taken using a service based approach as opposed to a needs based approach. The use of a service based approach, however, was not necessarily the best method for the rural hospitals because it is unable to take into account a wider concept of rural health or rural health services. In contrast, a needs based approach is designed to recognise the total health needs of a rural community, and to improve the hospital's ability to fulfil those needs should the community wish for the hospital to be retained. As a former Canterbury Area Health Board staff member who was managing the rural hospitals during this transition, commented:

We [didn't] say here's a community with a hospital in it, what services are currently being delivered from this hospital, do we want to continue to deliver those services, or do we want to develop a wider health service around that building for that community?. . . [It was] taking the here and now and saying what do we do with it, not saying here's the here and now, it looks like it might need modifying, let's put it in an environment that can modify it in the future to service the needs of the population.[30]

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[30]Interview, Former Canterbury Area Health Board staff member, 19 April 1996. This individual was also involved in the transition to the new CHE structure, but will continue to be referenced as a former Canterbury Area Health Board staff member.

Once the hospitals had been placed with a CHE, they then had to be integrated into the structure of the CHE itself. The two CHEs took different approaches to this task, initially causing much uncertainty as it was feared this could create the opportunity for the hospitals to be closed. In Canterbury Health, a needs-based approach was taken, and the hospitals were placed with Ashburton and Community Health Services on the basis that they shared a common philosophical background which could be mutually supportive:

It was a needs based decision . . .with the view that the people managing Ashburton would have a similar understanding of the problems, the threat of closure, of withdrawal of services, of the farming community, and wanting to . . . hopefully gather strength in each other's common understanding, and also being able to look at the needs of the community that they served, which were very similar, and so develop the services on a needs basis as opposed to an existing services basis.[31]

In contrast, the hospitals that agreed to go with Healthlink South were placed using a service based approach. As a result, Lincoln and Rangiora were located in the maternity division, and Oxford and Kaikoura were fitted into the elderly health division. Separating these hospitals administratively, however, bolstered concerns that as small, isolated units they would be more vulnerable to closure.[32]

Nonetheless, the restructuring did create the opportunity for some improvements to be made to the hospitals. This was particularly important as many of them were suffering from the deferred maintenance that had been prevalent under the Area Health Board.

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[31]Interview, Former Canterbury Area Health Board staff member, 19 April 1996.
[32]Interview, Former Canterbury Area Health Board staff member, 19 April 1996.

Crucially, fire sprinkler protection was installed, which, with other measures, made the hospitals more viable in the new era, and created a sense of security that helped offset some of the uncertainty and suspicion that had been produced by the reforms. As the former Canterbury Area Health Board staff member managing the hospitals commented:

We painted, spitted and polished, and it was really nice to have those carrots to offer people, that the health reforms [weren't] all bad, Look you're getting this and this and this, and they did. . . and it was a positive thing for all of them, so they felt much more secure.[33]

The Lead Up to the 1993 Election

The approach of the 1993 general election was an anxious time for the rural hospitals. The government, and the new RHAs and CHEs were being coy about the future of rural hospitals, to prevent adverse public reaction. Instead, the government concentrated on bedding down the reforms, and attempting to generate support for them prior to the election. This, however, was not an easy task. Network Communications, another public relations company contracted by the Health Reforms Coordination and Communications Unit to assess public response to the reforms, recorded that they were seen as "costly, unfair, and ill-considered."[34] The Tamaki by-election in 1992, which National came close to losing, also signalled the need for an advertising campaign to turn the tide of public opinion. However, that campaign was not initiated until May 1993, and as Easton argues, the damage had already been done and the campaign came too late to be effective.[35]

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[33]Interview, Former Canterbury Area Health Board staff member, 19 April 1996.
[34]Atkinson, "Health Reforms and 'Thin' Democracy", op. cit., p. 201.
[35]Easton, "How Did The Health Reforms Blitzkrieg Fail?", op. cit., p. 229.

The difficulties of accomplishing such radical reform so quickly also meant that much of the ideology of the reforms had been sacrificed to the practicalities of implementation. Intense public opposition and serious administrative difficulties meant that by the end of 1992 the government had abandoned Health Care Plans, and agreed to continue the funding of the health system through taxation. Furthermore, the National Advisory Committee on Core Health Services had rejected the idea of producing an explicit list of services and, instead, was focusing on gathering information on the costs and effectiveness of current health services.[36]

In spite of the backdown of the government in these areas, public discontent continued to be fuelled by the Crown Health Enterprises, particularly with their strong commercial focus. In part, this stemmed from the requirement in the draft Health and Disability and Services Bill that CHEs be as "profitable and efficient as comparable business not owned by the Crown."[37] Strong public criticism that CHEs would be more concerned with making a return on their assets rather than providing health services meant that the word "profitable" was replaced with "successful," but this alteration did not ease the public's concern, as the change seemed to do little to alter the spirit of the law.[38] This change also did not clarify the relationship between the dual requirements that the CHEs act as successful businesses as well as being socially responsible to the communities they served. As these commercial and social objectives could very easily conflict with each other, this only further confused the exact role of the CHEs.

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[36]See Jacqueline Cumming, "Core Services and Priority Setting: The New Zealand Experience", *Health Policy*, vol. 29, 1994, pp. 41-60.

[37]Health and Disability Services Bill, 1992, s.25.

[38]Toni Ashton, "From Evolution to Revolution: Restructuring The New Zealand Health System", *Health Care Analysis*, Vol. 1, 1993, p. 61.

The government's difficulties with the unpopular health reforms led to the replacement of Simon Upton as Minister of Health by Bill Birch in March 1993. Described as one of the "toughest administrators in the Cabinet," Birch was a more pragmatic politician than the intellectual Upton, and it was Birch who ultimately ensured that the RHAs and CHEs were operational by their deadline of July.[39] Birch was unwilling to let the issue of rural hospitals become a political liability for the government in the lead up to the election. This stance saw him intervene to guarantee surgical services for a further fourteen months at Balclutha Hospital which had been identified for closure by the new CHE.[40] This interference was in direct contrast to the recommendation of the National Interim Provider Board that CHEs should be free from political interference, and led the chairman of the Otago Crown Health Enterprise Advisory Committee, Sir Clifford Skeggs, to resign in protest.[41] Although Birch argued the intervention was to allow communities sufficient time to evaluate whether the services could be retained in some other way, his interference was a clear indication of a government under pressure with the health reforms.[42]

Exacerbating the government's position were the unresolved financial troubles of the CHEs. Two days before the reforms were to come into effect, the government announced that CHEs which ran into serious financial trouble would receive a capital injection. This would involve restructuring their balance sheets to return them to a commercial position. A $200 million loan facility was also set up for CHEs to borrow

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[39]Easton, "How Did the Health Reforms Blitzkrieg Fail?", op. cit., p. 230.

[40]Astrid Smeele, "Short Reprieve for Balclutha Hospital", *Otago Daily Times*, 21 May 1993, p. 1; Oliver Riddell, "Birch's Action Over Hospital Angers CHE", *Christchurch Press*, 24 May 1993, p. 6.

[41]Evening Post, "Skeggs Quits, Citing Interference By Govt', 25 May 1993, p. 1.

[42]Bill Birch, "Birch's Breathing Space", *New Zealand Herald*, 12 June 1993, p. 8.

extra money to cover capital works, maintenance, and any shortfalls in the cost of providing services.

For rural hospitals, however, the implementation of the reforms in July brought a renewed sense of security. This was because in the first year of the reforms, the government announced that all existing services would be purchased on a roll over basis. In this agreement, the government directed the RHAs to purchase the same range and volume of services from the CHEs as had been provided by the Area Health Board for 98% of the AHB's former funding. This roll over was partly motivated by the recognition that much of the necessary information required to operate a market in health was still missing. The CHEs did not have the information on the costs of their services, and hence could not produce adequate information on the prices they would require for their services; this made it virtually impossible for the RHAs to engage in any competitive tendering.[43] The roll over of services also meant that no major surprises would be generated by the health sector in the run up to the election.

In the 1993 general election in November, health, and more specifically the government's health reforms, became a key issue. Although the government continued to promote the reforms, the lack of public consultation, the strong commercial emphasis of the CHEs, and the growing waiting lists meant that many segments of society were still unconvinced of the merit of the reforms. As a result, the government only narrowly regained power, and lost the huge majority that had characterised their win in 1990. After the election, Jenny Shipley

[43]See Toni Ashton, "The Purchaser-Provider Split in New Zealand: The Story So Far", *Australian Health Review*, vol. 18, no. 1, 1995, pp. 43-59; Colleen Flood and Michael Trebilcock, "Voice and Exit in New Zealand's Health Care Sector", *Contracting in the Health Sector*, Auckland: The Foundation, 1994.

replaced Bill Birch as the new Minister of Health, and rejected calls to abandon the reforms. Instead, she argued that her role was to make the reforms succeed to benefit the people of New Zealand.

This was not to be an easy task, however, particularly as the Ministry of Health's post-election briefing document warned the government of the likelihood of rural hospital closure. Due to a combination of factors, including underdeveloped management systems, operating deficits, and valuation and balance sheet difficulties, the briefing document identified that CHEs were experiencing severe financial difficulties and were not independent, financially viable units. Although the government had created the Residual Health Management Unit as a source of temporary finance for CHEs, it was acknowledged that CHEs would have to make significant efficiency gains, and where possible, find alternative sources of revenue to the RHAs to become financially viable. Crucially, the briefing document noted that efficiency gains were most likely to involve a "reconfiguration" in the way CHEs currently did business, and that this was likely to entail "reducing or closing uneconomic satellite hospitals, particularly in rural areas."[44]

The briefing document also emphasised that the population based funding of RHAs, and the moves to bring RHAs to funding equity, meant that some CHEs, particularly those in the South Island, were going to be seriously affected. Under the reforms, the funding of RHAs for personal health and disability support services is determined by a population based funding formula. This formula calculates each RHA's share of the total available funding according to the size and

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[44]Ministry of Health, *Ministry of Health Post Election Briefing: Strategic Issues in the Health Sector*, Vol. 1., Wellington: Ministry of Health, November 1993, p. 31.

characteristics of their population and the factors affecting the need for health services. These entitlements are known as 'equity'. This equity is then compared to the 'nominal funding' to be given to the RHA in the year to ascertain whether an RHA is over-funded, that is above equity, or under-funded, that is below equity. The government then makes adjustments to the current or nominal funding to move the RHAs closer to equity.[45]

The move to equity funding was particularly significant for the Southern RHA because it was identified as being over-funded, and hence would not receive the same increases in funding as RHAs in the North Island. This problem was also exacerbated for the Southern RHA by the increasing amounts of revenue being absorbed by the demand driven areas of primary care and pharmaceutical expenditure. As a consequence, the move to equity funding meant that unless the SRHA could control or reduce its demand driven expenditure, it would have fewer resources available to fund health services delivered by CHEs. This would place even greater pressure on CHEs to make efficiency gains through such measures as the closure of rural hospitals. Community resistance to proposed closures, however, was likely to create strong pressure to review the means of funding RHAs. The post election briefing document acknowledged that the government could pay CHEs additional subsidies to improve their financial position, but asserted that such measures were likely to reduce the incentives for CHEs to behave efficiently.[46]

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[45]Ministry of Health, *Purchasing For Your Health: A Performance Report on the First Year of the Regional Health Authorities and the Public Health Commission*, Wellington: Performance Monitoring and Review Unit, Ministry of Health, 1994.

[46]Ministry of Health, *Ministry of Health Post Election Briefing: Strategic Issues in the Health Sector*, op. cit., p. 31.

The financial troubles of the CHEs continued to cause difficulties for the government. In December 1993, the chair of the Crown Health Enterprise Boards' Consultative Committee wrote to the Ministers of Health, Finance and Crown Health Enterprises criticising the commercial environment in which they were to operate. In particular, the group stated "this business of providing health is not a genuine commercial mode. We are not able to significantly influence the market, adjust prices or alter the nature of supply in order to capture a market in the way other commercial organisations do."[47] The severity of the CHE's financial position led to an increase of $125 million in health spending in the post election Budget. This funding increase was to boost the position of the CHEs, but was also to improve the ability of the RHAs to purchase services from the CHEs.[48] In early 1994, Healthcare Otago announced its intention to bid for a contract to manage private hospitals in Saudi Arabia. For a CHE in financial crisis, the Saudi venture offered a valuable source of alternative revenue. The actions of the CHE, however, caused an intense political controversy, which resulted in strong criticism that the venture would prevent the CHE from fulfilling its primary obligation of providing quality health and disability support services to its own region. The political embarrassment led to the resignation of the CHE's Chief Executive Officer, James Patterson.

Conclusions

By the beginning of 1994, the transformation of the health system to a 'managed market' was complete. The initial design of the reforms had

[47]P Wilson, Letter to the Hon. Jenny Shipley, Minister of Health, Hon Paul East, Minister of Crown Health Enterprises, and Rt. Hon. Bill Birch, Minister of Finance, 17 December 1993.
[48]Michael Rentoul, "Health gets $125m Top-Up from Govt", *Christchurch Press*, 3 March 1994.

been modified by the government in light of the intense public opposition to them, and as the ideological basis of the reforms had clashed with the political realities of implementing and administering such a system. In spite of these modifications, however, the reforms had still created an institutional structure that significantly altered the power of the key interests in the system. Between the financially troubled CHEs and the directives governing the purchasing strategies of the RHAs, rural hospitals were positioned extremely precariously. For rural communities seeking to retain their hospitals, the reformed health system would present them with their greatest challenge to date.

Chapter Five: Implementation of the Health Reforms: Unanticipated Power Relationships Between the RHA, CHE and Local Communities

Introduction

As discussed in Chapter Four, by the beginning of 1994, the government had redesigned the health system to resemble a 'managed market.' The separation of the purchasing of health services from their provision had attempted to undo what was perceived as provider and community capture by eliminating the veto point offered by Area Health Boards. The government seemed better placed to impose more stringently its imperatives of fiscal control and equity on the system, while the abolition of directly elected Area Health Boards meant local communities no longer had formal representation in the system. According to the design of the reforms, these communities would be less able to resist attempts by RHAs and CHEs to redistribute resources in the health system through the closure of rural hospitals.

However, once the roll over of services required in the first year of the reforms had concluded in mid 1994, the reforms began to produce a more fluid distribution of power among RHAs, CHEs and rural communities than the government had intended. Both the CHEs and rural communities demonstrated an ability to influence the decisions of the RHAs, despite the desire of the reformers for the RHAs to hold the more powerful position. The power of rural communities to retain their hospitals has stemmed from their ability to benefit from the particular mix of political factors at the national and local level generated by the prospect of rural hospital closure and the unpopularity of the health reforms. Paradoxically, this has meant that the desire of the reformers

to remove the spectre of 'politics' from resource decisions in health has proved impossible to achieve. Instead, it is the politics created by the new system that local communities and CHEs have learned to exploit so as to improve their position.

The Southern Regional Health Authority and the Dilemma of Rural Hospitals: Planning for the South

When the RHAs came into existence in 1993, they were directed by central government to develop purchasing strategies that would improve equity of access to health services for their respective populations.[1] Inherent in this requirement, however, was a conflict between financial cost and the demands of communities for the retention of current levels of services. In the Southern region, these competing tensions were especially acute because of the particular characteristics of the region. First, the SRHA had assumed responsibility for an area representing 48 per cent of the New Zealand land mass. In this area, only two thirds of the population lived in cities, with the remainder being thinly dispersed, often in places without good public transport and subject to adverse weather conditions.[2] Hence, for the SRHA to improve equity of access for all its citizens, it would need to either substantially increase the amount of resources being devoted to services in those remote areas, or significantly redistribute existing resources.

Moreover, the SRHA also identified that serious inequities existed in the delivery of health services within the region, arguing that services

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[1]Interview, SRHA staff member, 11 December 1996. This requirement to improve access is reflected in the six principles which govern the purchasing decisions of RHAs. The first principle is 'equity', and requires RHAs to "improve access of New Zealanders to health and disability services in terms of waiting times, geographical accessibility and affordability." Source: Ministry of Health, *Policy Guidelines for Regional Health Authorities 1994/95*, Wellington: Ministry of Health, 1994, p. 8.

[2]Southern Regional Health Authority, *Planning For The South: Access to Health and Disability Services in the Southern Region*, Dunedin: Southern Regional Health Authority, June 1994, p. 6.

were being delivered in an unplanned fashion based more on historical circumstances than on the present needs of communities.[3] In particular, the SRHA considered that those communities with rural hospitals close to the facilities of a major city enjoyed a luxury, or above average level of hospital service, in comparison to rest of the region. Budgetary constraints imposed by the move to equity funding meant the SRHA would have to sacrifice services in the more advantaged areas to make gains in access for those in the 'worst off' areas.

Although the SRHA knew communities faced with the prospect of losing services or facilities would vehemently oppose such moves, the SRHA was constrained by its directives from government which require it to act in the best interests of the region as a whole. As a result, the SRHA used the time provided by the roll over of services in 1993/1994 to begin work on a set of criteria that would allow for a more structured approach to the purchasing of health services in rural areas that would also redress some of the existing inequities. The first step in this process was a survey conducted in August 1993 that asked over 5000 residents of the Southern region what amount of time they thought was reasonable to spend travelling to receive certain health and disability services.[4] These responses were then analysed, and in December 1993 the RHA released a discussion document entitled *Access To Care* which outlined a range of travel times to a variety of health and disability services. The public's response to these times was then incorporated with the reaction from the RHA's consultation committees, and the results released in June 1994 in a planning document entitled *Planning for the South.*[5]

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[3]Southern Regional Health Authority, *Planning For The South,* op. cit., p.3.

[4]Ibid, p. 10.

[5]Southern Regional Health Authority, *Planning For The South: Access to Health and Disability Services in the Southern Region,* Dunedin: Southern Regional Health Authority, June 1994.

Essentially, *Planning for the South* outlined a framework where access to health and disability support services would be based on the size of a community's population, and the travel time by motor car to services. It set out four levels of care (levels A to D), and stated 90% of the population should have access to those levels within respectively, 30 minutes, 60 minutes, 90 minutes, and 90 minutes or more. With respect to hospital services, the SRHA specified that communities should have access to what it considered to be an appropriate range of hospital services according to their population size. For populations reaching 10,000 it was argued that 90% of those people should have access to a basic range of community services within 30 minutes, but that this did not include "hospital facilities."[6] The exception to this was for populations that were one hour or more travel time from their next neighbouring centre, and it was considered that these populations should have a basic range of inpatient beds, managed by their local general practitioners. Those populations were specifically identified, and in Canterbury they included Akaroa and Waikari, but excluded Darfield and Ellesmere.

Crucially, the criteria laid out in *Planning for the South* did not mean that hospitals such as Darfield would automatically close, but that the SRHA was prepared to pay only its benchmark price for the services provided at those facilities. In contrast, for hospitals like Akaroa and Waikari, which are an hour or more from the facilities of Christchurch, and hence considered to be more geographically isolated, the SRHA was willing to pay a premium, or an amount in addition to its benchmark price, to ensure services were provided in those areas.

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[6]Ibid, pp. 11-17.

Planning for the South was a watershed document in that it represented a critical change to the means that had been used to determine the provision of rural hospital services. Under the Hospital and Area Health Boards, the provision of hospital services depended primarily on utilisation levels and financial viability, as well as on the historical provision of services which could be perpetuated by key individuals defending the interests of rural hospitals at the Board level. This approach was reinforced by rural communities themselves who were willing to find services for the hospital to perform in order to retain it, with little consideration as to whether having increased hospital services was the best use of those resources for their community. As a result, regional planning of services was much more unstructured before the health reforms, and as one interviewee commented, there was not the same "clarity about what could be expected about access times to services" under the Area Health Board system.[7] With *Planning for the South* and the change to travelling times and population size as the critical criteria, the SRHA believed it could take a more consistent and structured approach to the purchase of services that would also attempt to redress some of the existing inequities in the distribution of services throughout the region. As an SRHA staff member commented:

. . . [Planning for the South] *tried to set out a structured approach to what should be purchased around the rural regions in the light of some considerable inequities around the place, and to base our purchasing, in the absence of any other better information, on what's a reasonable time for people to access something . . . So it was really saying in terms of what is the urgency of need to access services what's appropriate for scattered populations, recognising you can't have everything on your door step.*[8]

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[7]Interview, Southern Regional Health Authority, staff member, 27 May 1996.
[8]Interview, Southern Regional Health Authority, staff member, 27 May 1996.

The SRHA, however, also recognised that *Planning for the South* was only a starting point for discussions over local services, as it would be inappropriate to apply the framework rigidly to communities. As a result, the SRHA also developed the concept of locality planning, which was specifically intended to tailor the framework set out in *Planning for the South* to the individual needs of communities. Formally, locality planning comprises two parts. The first is building a picture of the locality through the collection of data on its geography, climate and demographic characteristics, as well as on the range of health services currently available, the access to those services, the particular health needs of that community, and how the community views its present health services. Second, locality planning entails defining the standard prices for each component of the service the RHA wishes to purchase, comparing those prices with the actual services in the locality, and developing plans for any changes.[9] The locality profiles were intended to work in conjunction with these criteria, particularly as *Planning for the South* did not cover all health and disability support services, to allow the SRHA to obtain a more detailed understanding of the health needs of communities and develop precise packages of services to meet those needs.

The reaction of rural communities to *Planning for the South*, however, was intense, and strongly negative. Around the region, rural communities perceived the SRHA's criteria would mean the closure of their local facilities, or the loss of vital surgical services. To some extent, this reaction can be attributed to the SRHA not effectively

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[9]Southern Regional Health Authority, *Southern Regional Health Authority Draft Purchase Plan 1994/95*, Dunedin: Southern Regional Health Authority, 1994, p.113.

communicating the importance of locality planning to the implementation of the *Planning for the South* framework. Although *Planning for the South* had discussed locality planning and acknowledged that the need for in-patient beds would be discussed as part of the locality planning initiative, the document's focus was clearly on the levels of care and the SRHA's criteria for the provision of hospital services. The media releases accompanying *Planning for the South* also exacerbated this situation because they contained statements implying that rural hospital services throughout the region would be slashed, and that there would be no flexibility from the SRHA. As one SRHA spokesperson recalled:

. . . the mistake we made in [the media releases] was not saying this is the interpretation for your area, it's negotiable. . . . What did come out was the appearance of a fait accompli, it was complete, that was the end of it, that was our view, and that was it.[10]

As a result, the reaction in rural communities to *Planning for the South* was rapid and impassioned, particularly in Ashburton, Balclutha and Oamaru who, under the SRHA's criteria, would lose key in-patient surgical services.[11] In spite of this public reaction to *Planning for the South*, rural communities had no means of changing the criteria of the SRHA, and it fell to the CHEs, as the owners of the facilities, to decide whether they wished to continue providing rural hospital services. In a fascinating contrast, however, the CHEs in Canterbury and Otago would react quite differently to the SRHA's criteria, and these reactions

[10]Interview, Southern Regional Health Authority, staff member, 27 May 1996. This was also mentioned in interviews with Canterbury Health staff.

[11]Specifically, *Planning For The South* stated that it would only purchase specialist medical and surgical services from Class C hospitals, or those serving over 25,000 people. As Ashburton's population was 24,700 it did not fall inside this criteria. Also, the SRHA identified in *Planning For The South* that for populations serving up to 25,000 people, (of which it identified the districts of Ashburton, Oamaru, Central Otago/Lakes district, Clutha and Eastern Southland), Ashburton, Oamaru and Clutha exceeded the proposed level of services for populations of that size, while Central Otago/Lakes district and Eastern Southland fell short.

unexpectedly became the critical factors that dictated where the SRHA was to focus its attention.

Critical Role of the CHEs: Contrasting Decisions of Healthcare Otago and Canterbury Health

Although the design of the health reforms sought to give RHAs the ability to set the agenda for changes to services in their regions, in practice, often it has been the RHAs who are compelled to react to the decisions made in the first instance by the CHEs. In the Southern region, the release of the SRHA's criteria for the purchase of hospital services prompted two very different reactions from the CHEs in Canterbury and Otago. In Otago, the CHE announced an immediate withdrawal from Tapanui, Milton and Roxburgh hospitals,[12] while Canterbury Health agreed to continue providing services at its four rural hospitals in the short term.

In essence, the motivations for these different approaches can be traced to the history of the two CHEs and their financial position. In Otago, the CHE was based on what had been the Otago Area Health Board. As a result, it became responsible for much of the same area, inherited the same problems, and employed many of the former Area Health Board staff. The Otago Area Health Board, however, had been wanting to close and downsize many of its rural hospitals for a number of years, and in the transfer of staff between the Board and the CHE, this "corporate history" surrounding rural hospitals was carried over. As that history had been one of wanting to reduce rural hospitals, as one interviewee commented, "[Healthcare Otago] just simply followed through with

[12]Interview, Southern Regional Health Authority staff member, 28 May 1996.

plans that they'd had in place for a long time . . . [and] *Planning For The South* gave them a bit more momentum."[13] As a financially troubled CHE, *Planning for the South* allowed Healthcare Otago to reduce some of the financial pressure on its budget by withdrawing from rural hospital services, while at the same time, conveniently deflecting public hostility and blame towards the planning document and the SRHA.

In contrast, the corporate history surrounding rural hospitals in Canterbury was much more positive than in Otago. The 1990 review of rural hospitals had found they provided a valuable service, and that there was not a clear case for closing them. In the process that established the CHEs, the Canterbury Area Health Board was divided into two CHEs. This meant the former staff of the Area Health Board were more widely dispersed as they had the choice of two new CHEs and the Southern Regional Health Authority from which to seek employment. As a result, the CHEs in Canterbury contained more new staff than in Otago, and so the depth of corporate memory that was carried over in Otago did not occur in Canterbury. Moreover, as the corporate history surrounding the rural hospitals in Canterbury was more supportive than in Otago, this meant Canterbury Health and Healthlink South, were more willing to continue providing services from rural hospitals than Healthcare Otago.[14]

These different approaches had enormous implications for the SRHA. Instead of being able to plan where changes to services would occur throughout the region, the SRHA was unfortunately placed in the position of having to address the immediate needs of the communities

[13]Interview, Southern Regional Health Authority staff member, 11 December 1996.
[14]Interview, Southern Regional Health Authority staff member, 11 December 1996.

in Otago affected by the CHE's withdrawal. In contrast to Canterbury, where there was no pressure to find an alternative provider, the SRHA immediately had to begin working with communities in Otago to identify the services it wished to purchase and contract those services out to a new provider. For the SRHA, the need to become involved so quickly with communities raised a number of very difficult issues, both in terms of its own role as the purchaser of services, and in understanding the impact of a hospital closure on a rural community. Together, these issues placed huge demands on the SRHA, as it had to do an enormous amount of learning very rapidly, while also being expected to develop solutions to the difficulties created by Healthcare Otago's withdrawal. As a result, the initial relationship between the SRHA and the Otago communities was characterised by confusion, frustration, slow progress and poor communication.

Although the reforms sought to empower CHEs to make decisions such as withdrawing from providing rural hospital services, in practice this power serves to create the new problems that the RHAs and communities must resolve. In the Southern region, when Healthcare Otago withdrew from Tapanui, Milton and Roxburgh hospitals, it meant the new SRHA had to go into these communities without having its own purchasing strategies or policy positions finalised, and so "not really knowing what [it was] going to say."[15] This lack of developed policy became a significant barrier to the relationship between the SRHA and the communities, because it meant that in the discussions held prior to Healthcare Otago's notice of withdrawal, the SRHA had given

[15]Interview, Southern Regional Health Authority staff member, 28 May 1996. Please note the following references refer to interviews conducted with different staff members on the same day.

communities "lots of confused messages" over the implications for health services of the CHE's withdrawal.[16]

This initial confusion was heightened after the CHE's decision to withdraw had been publicly announced. At this time, the SRHA held a series of public meetings to try and explain to the communities what it perceived to be the central issues concerning the provision of health services in their localities. At these meetings, however, the communities were met by a number of different staff, including members of the SRHA's Board, and representatives from each of the policy sections, all with different messages about how services would be purchased by their section. The SRHA also sought to assure the communities that services would be maintained in their localities, and that there would be no gap in the service between the CHE's withdrawal and the start of the new provider. The SRHA subsequently discovered, however, that communities did not always understand that the SRHA was referring to the purchase of particular health services, and consequently communities had misinterpreted these statements to mean that the hospital would remain open.[17]

Progress on determining the appropriate range and volume of services to be purchased in these communities was also hampered by a number of factors. First, the speed with which the SRHA was required to go into these communities meant it did not have "clear policy" on how it was going to purchase particular services.[18] Without this specific knowledge on appropriate volumes and the price of each service, the SRHA was

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[16]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[17]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[18]Interview, Southern Regional Health Authority staff member, 28 May 1996.

unable to make significant progress with the communities. As one SRHA staff member recalled:

. . . lots of promises had been made [and] although we knew we were going to buy district nursing, meals on wheels, speech language therapy, physiotherapy, and OT in those places, we didn't know volumes of the services we were going to be purchasing, nor we did know the dollar value. So at the high level, you had the information that they needed, but once you actually started to advance those discussions, you couldn't, and you just ended up tripping over each other.[19]

As a result, this increased the communities' feelings of frustration because the SRHA could not give them exact answers to their questions on the range and volume of services that were going to be available in their localities.

Furthermore, the SRHA was hampered by the lack of specific data from Healthcare Otago on what volume of services were currently being provided to those localities. As one SRHA spokesperson recalls "[t]he same CHE would give us three different sets of volumes for visits in the one community over the same period, and they would range wildly."[20] As a result, the SRHA spent considerable time deciding what would be an appropriate level on which to base its purchasing decisions. Eventually, it used a regional average as a starting point for discussions with communities over the level of service to be purchased, but warned communities that this would be only an interim level of service until the locality planning profiles were complete. This lack of data did, however, reinforce to the SRHA the importance of the locality planning profiles to gaining a better understanding of the health needs of communities.[21]

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[19]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[20]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[21]Interview, Southern Regional Health Authority staff member, 28 May 1996.

The SRHA considered that its progress in identifying the services it needed to purchase was hampered by communities' misunderstanding of the SRHA's function. It also became clear to the SRHA how differently rural communities view their hospitals from RHAs, CHEs and government. When the SRHA began working with the Otago communities, it was with the intention of identifying and purchasing health services, but the SRHA rapidly discovered that significant parts of the communities were still focused on retaining the hospital. As one SRHA spokesperson recalled, "we were talking services and improving them, and they wanted to maintain a building."[22] To a large extent, this desire to save the hospital can be attributed to the groups that the SRHA became involved with when it began working with the communities. As a new organisation, the SRHA had no established relationship with these communities, and so initially worked with the groups organised around the hospital. Rather than understanding that the emphasis of the new RHAs and CHEs was on the purchase and provision of health services, the SRHA perceived that these community groups were still locked into the mode of 'save the hospital' that had developed under the Area Health Board system. Nevertheless, the result for the SRHA was it had to spend considerable time explaining to communities that its focus was on improving services and not maintaining buildings.

This difference in orientation, however, was central to the way in which the SRHA and communities perceived each other, and to how successfully they were able to work together. For communities, the concept of health services as discrete units which can be individually defined, priced, and unbundled and rebundled into precise packages was

[22]Interview, Southern Regional Health Authority staff member, 28 May 1996.

alien for two key reasons. The first was that treating services as individual commodities is the antithesis to the interconnectedness of health services that characterises many rural communities. Due to the small size and relative isolation of rural communities, health services are often highly interconnected. In a rural community, the GP will often rely on the hospital as a source of professional support, while the presence of a hospital encourages and maintains the presence of GP and pharmaceutical services, and supports other services like meals on wheels. This interdependence also extends beyond the formal health care providers to other areas of the community including the school, local businesses and other voluntary services such as ambulance and fire. It may also be reinforced by the duplication of roles by the local medical staff. This is particularly common with nurses, who may be employed by both the GP and the hospital, and may also be associated with district nursing. For rural people, however, these services form a complex but fragile network where the loss of one service may threaten the viability of others.[23]

Rural communities also see their hospital as more than just a collection of services, because of the wider social and symbolic functions the hospital performs. As interviews in Darfield showed, rural communities not only have an emotional or parochial attachment to the 'bricks and mortar' of their hospital, but perceive the hospital as a symbol of the community's heritage and its contemporary identity. Particularly to the elderly, the hospital represents a vital source of security, that in many instances allows these people to feel that they can remain in the community. It is a very important focus for the community,

[23]For one of the best examples of this interconnectedness of health services, see Canterbury Area Health Board, Secondary Care Division, *Report of the Rural Hospitals and Rural Health Needs Review*, op. cit.

particularly in relation to the huge amount of volunteer work that local communities do to support the hospital. The hospital is also considered a vital part of the rural community's life blood, and its presence also allows the community to feel valued. In general, urban areas feel important as a consequence of being geographically and demographically large, but smaller communities tend to look at the facilities they can support to derive a sense of community worth.

This perception of status is difficult to quantify, because it is closely intertwined with the feelings of rural people about the level of services provided in the city. In essence, rural people feel that they must fight to retain their health services, such as those provided by their local hospital, yet city people have it 'all laid on for them' purely because that is where the majority of the population is situated. Although rural people accept that more services should be available in the city, they also feel that in times of financial hardship, it always the rural areas who are the first to experience cutbacks to services. The smaller the community, the more vulnerable they feel to these losses, and so the retention of facilities like the hospital, particularly because of its crucial place in maintaining other health services in the district, becomes an even more important means of protecting the community's viability.[24] This reliance on the hospital as a valuable means of ensuring the community's survival can be seen in the comment of an SRHA staff member working with rural communities in Otago. She perceived that:

. . .in Lumsden [the loss of the hospital would be] yet another indication that the town is dying because they've already got half of Lumsden on the market,

[24]For additional detail, see NACCHDSS, *Symposium on the Delivery of Health Services to Smaller Communities*, op. cit., and Heather McCrostie Little and Nick Taylor, *Means of Survival? A Study of Off-Farm Employment*, op. cit.

and here's yet another building, and it just represents to the community that here's another building dying.[25]

The SRHA has "struggled" with understanding the significance of rural hospitals to their communities, especially as the SRHA also felt that communities were largely ignorant of the actual services provided by the hospital.[26] As an SRHA spokesperson commented

if you'd asked Ashburton 18 months ago, when the heat was on, what services are actually provided in Ashburton hospital, I think you'd be surprised at the level of ignorance . . . it's just the fact that the hospital is there.[27]

This emotional attachment to rural hospitals has only enhanced the SRHA's belief that these hospitals are "grass roots security symbols" which not only consume a large number of resources but are often "totally inappropriate" for the health needs of the community.[28] Moreover, the SRHA also recognised that many residents in rural communities will not use their local hospital, but will instead travel to the facilities of the base hospital in the city. As rural hospitals provide only primary medical care, the SRHA perceived that they could be replaced by community based services which would not only give the community more services for the equivalent level of resources, but would also deliver services that are more appropriate to the community's needs.

As no organisation before the SRHA had been required to work with rural communities experiencing the loss of a hospital in the same way, the SRHA had to grasp the significance of the hospital to the

[25]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[26]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[27]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[28]Interview, Southern Regional Health Authority staff member, 28 May 1996.

communities in a very short space of time. The lack of understanding of both the SRHA and the Otago communities for the position and point of view of the other, however, meant that their relationship became increasingly strained. Consequently, the SRHA found that there was much "cross talking" between themselves and the communities, and that this began to improve only when key individuals within the community began to see the issue from the same perspective as the SRHA. As one SRHA staff member commented,

. . . quite a period of cross talking [would go on] until you would find an advocate in the organisation who could actually understand what was going on, and then he or she usually became the interpreter, and I think of two or three key meetings where people have got particularly grumpy, say at the public meeting, and then the leader of the . . . whatever you call it, has stood up and said look, we can't keep focusing on the past, we've just to start looking forward, and there's been a critical turning point. I think at almost all the meetings we've been in, a particular person has stood up and done that, and that's really been where things have started to turn.[29]

As another staff member reiterated,

once you actually get to work with those sort of people, you're talking the same language. [30]

Ironically, a feature of the health reforms has been that a new language has evolved, which is often alien to those outside the system. The acronyms RHA and CHE, and the differences between the two organisations are frequently misunderstood by the public. Terms like health purchasers and providers are more closely allied to the business world than to the language of nuture and caring associated with the

[29]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[30]Interview, Southern Regional Health Authority staff member, 28 May 1996.

health sector in the past. The RHA's use of words like "consultation" to mean "listening but not necessarily acting on" conflicts with the public understanding that "consultation" implies having some influence on the issue at hand. These disparities not only hinder effective communication between the two parties, but also privilege the RHA and the CHEs.

Exacerbating the "cross-talking" between the SRHA and the Otago communities, however, was the identification by the SRHA of a grieving process when a hospital closure is announced, similar to that experienced by humans at the death of close relatives and friends. The most significant work on grieving has been done by Elizabeth Kübler-Ross, who identifies a multi stage process, where people experience the five stages of denial, anger, bargaining and depression before the final stage of acceptance is reached.[31] In hindsight, the SRHA realised it had not been sensitive to this process, and had entered into discussions with communities on their future health services before the communities had been given the opportunity to address adequately their feelings of loss. Initiating discussions while communities were still in the first stages of grief, however, meant that effective communication was very difficult, because, as one SRHA spokesperson commented "in the height of grief, people [hear] what they want to hear, or what they don't want to hear."[32] As the SRHA saw it, this grieving process also heightened the emotional attachment of communities to their hospital and prevented them from clearly perceiving the germane issues. Since their experience with rural communities in Otago, however, the SRHA now recognise that time is crucial to allowing communities the opportunity to work through the

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[31]Elisabeth Kübler-Ross, *On Death and Dying*, New York: Collier Books, 1969.
[32]Interview, Southern Regional Health Authority staff member, 28 May 1996.

grieving process so they are able to clearly address their health service needs within the limits acceptable to the SRHA.

A further unintended consequence of Healthcare Otago's withdrawal from rural hospital services in the Otago was to prompt the formation of community trusts to allow communities to be responsible for their own health services. In contrast to Canterbury, rural communities in Otago did not have the luxury of a supportive CHE, and consequently had little choice but to form a trust if they wished to maintain their hospitals. Encouraging communities to form trusts in Otago was the release of the Transitional Assistance Funding in August 1994. The transitional assistance funding consisted of $20 million, and was made available by the government in response to public concern about changes to services such as the closure of rural hospitals being brought about by the health reforms. Accordingly, the funding was designed to ensure that health services would be continued during any transition to a new provider, and to assist with the development of new health services initiatives including community trusts.[33]

The release of the funding, however, was described by an RHA employee as a "nightmare."[34] As the SRHA saw it, the transitional assistance funding raised communities' expectations over their ability to form and run trusts, and increased the pressure on the SRHA "because there [were] a lot of communities who we hadn't been working with [who] suddenly got in on the act."[35] Encouraging communities to apply for grants to investigate the option of forming trusts also provided "an

[33]Minister of Health, Media Release, "Transitional Assistance For New Service Development", 19 August 1994.
[34]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[35]Interview, Southern Regional Health Authority staff member, 28 May 1996.

awful lot of income for consultants to come to us and ask us what we were doing."[36] Unfortunately for the communities, as these consultants did not have the appropriate experience or knowledge to produce good studies, the position of the communities was not significantly advanced.

The wish of communities to form trusts, however, raised numerous issues for the SRHA. The original reforms offered very little formal help for communities wishing to establish trusts, and eventually the role was passed to RHAs. As one SRHA spokesperson recalled, "[t]hey had someone initially in Wellington who went out to talk to local communities, and they found it too hard, so [it was] RHAs you take it up."[37] Due to the high degree of community ignorance over the issues involved with community trusts, the SRHA found itself in a position of having to spend an enormous amount of time educating communities on very basic things such as the working of the health sector, how to prepare a business plan, and how to contract for services.

Not only did the formation of trusts in Otago require the SRHA to be closely involved with these communities in an advisory capacity, but the SRHA perceived the trusts as "significant drivers" to discussions with the communities over their health services.[38] This is because for the SRHA the creation of a trust immediately establishes a formal structure at the local level which tends to precipitate the SRHA's involvement with these communities. The greater willingness to form trusts in Otago, however, meant that the SRHA gave more of its attention to these formal organisations than to communities such as Darfield where there was no formal structure lobbying the SRHA for a resolution to the issues.

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[36]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[37]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[38]Interview, Southern Regional Health Authority staff member, 28 May 1996.

Being so closely involved with these organisations and the transitional assistance funding proved difficult for the SRHA because it reinforced the communities' sense that their trust would be the preferred provider, when at the actual negotiations for services this was not always the case. As a consequence, the SRHA is now careful to make the framework very clear to communities, whereby the SRHA will work with them, but will not given them preferred provider status. As one SRHA spokesperson pointed out:

. . .you can be working with a provider, and developing providers, but making sure the policy is still very clear and consistent about tendering for services . . . so you don't actually end up in the situation of where the RHA's been captured by one particular community group, and therefore is unable to stand back and say does this look a viable business, because we like the people, or we spent months and months working with them, and therefore it's hard to detach yourself. And that's why we still say [to the communities] we'll work with you, but at the end of the day, in the new world, it's got to be the best quality service provided by the best and most able provider.[39]

Together, the lack of effective communication and the misunderstandings that had strained the relationship between the SRHA and the rural Otago communities culminated in making the communities feel extremely frustrated with the SRHA. In the same period, the National Advisory Committee on Core Health and Disability Support Services recognised the problems inherent in the need to provide health services to rural communities, and held a national symposium to begin addressing the difficulties experienced by both rural communities and RHAs. As the SRHA saw it, this conference intensified the feelings of the Otago communities, and resulted in their

[39]Interview, Southern Regional Health Authority staff member, 28 May 1996.

pressuring the SRHA's Board and senior management. In response to this pressure, the SRHA created an internal Rural Services Group, the objectives of which were:

. . . to come to an arrangement in each of the rural communities we were working with . . . to make sure that arrangement was fair, and to apply that approach consistently across the region.[40]

In setting up this group, the SRHA also sought to provide a "consistent point of contact," for communities.[41] Prior to the rural services group, the SRHA had brought out representatives from each of the policy sections to answer communities' questions, but this only confused and frustrated communities because they were constantly having to deal with different people, whom communities often felt were ignorant about what had happened in the past, and knew little of the needs of their particular areas.

From this rural services group, the SRHA developed a set of principles and a clear process which they could then apply to all rural areas. In essence, this approach contained four key components. The first was to establish what services were to be provided in the community. For the SRHA, this question contained two parts: what services should be available to the residents of an individual community, and also what services should be provided for the residents of that community taking into account the services available to other areas in the region. The second component involves the level of service that should be provided; the third aspect is deciding who should provide those services; and the final element is establishing the price to be paid for the services.

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[40]Interview, Southern Regional Health Authority staff member, 28 May 1996.
[41]Interview, Southern Regional Health Authority staff member, 28 May 1996.

However, the SRHA has perceived that communities tend to reverse the order, and assumes that the SRHA starts with the price, which then determines the provider which in turn affects what will be delivered and how.[42] Such a misconception by the communities inevitably causes conflict with the SRHA.

As a result of their experience with communities in Otago, the SRHA has been "doing quite a lot of questioning" about its approach, and seeks to alter it for other communities by using the information from the locality profiles to create a more detailed understanding of the health needs of communities.[43] Together, the information from the locality profiles and the criteria in *Planning for the South* will help inform the SRHA's decisions on what range and volume of services to purchase. In this way, the SRHA hopes to avoid being drawn into debates centred around individual facilities, but will be better able to assess the needs of individual communities while also considering the needs of the entire region. As one SRHA spokesperson commented:

What we want to do is avoid debates, as has tended to happen, focussing on particular communities. . . and actually think more holistically. So what are the needs of all communities in say Canterbury, not just those communities with a hospital. . . .So we're trying to think through, let's take a position first of all, what are the needs of the community, and then based on that, we then ask the questions about where is it best to have facilities. It's seeing the big picture first before getting drawn into discussions about what does this mean for Oxford, or what does this mean for Darfield and so on. I actually think that is a better position to take because it's more understandable. It doesn't avoid the tough questions.[44]

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[42]Interview, Southern Regional Health Authority staff member, 27 May 1996.
[43]Interview, Southern Regional Health Authority staff member, 27 May 1996.
[44]Interview, Southern Regional Health Authority staff member, 27 May 1996.

Although rural communities in Canterbury may well be able to benefit from the SRHA's revised approach in the future, at the time they had little involvement with the SRHA, which was dealing with more urgent issues created by Healthcare Otago's withdrawal from rural hospital services. This situation benefited the Darfield community because changes there were perceived by the SRHA to be of low priority, so the hospital was able to continue unchanged in the short term. The SRHA's experience in Otago was also extremely significant for communities in Canterbury, because it meant the SRHA had a greater understanding of the complexity of the issues raised by the closure of a rural hospital, and so was willing to delay making changes to the hospitals in Canterbury in the immediate future.

Darfield Hospital in the Context of National Politics: 1994-1996

In the formal design of the reforms, the government sought to insulate the RHAs, and to a lesser extent the CHEs, from the political pressure that communities had used in the past to influence the decisions of Area Health Boards. From 1994 to 1996, however, the events surrounding rural hospitals in Canterbury, such as Darfield, have shown that in spite of the loss of formal power endured by communities in the reforms, they are still able to remain key players in the debate over local services, and are capable of gaining some leverage over the RHA. The ability of communities to achieve this position, though, is dependent on the interplay of political factors at the local and national level, and how successfully communities can take advantage of those factors to fulfil their own goals. At the local level, these factors include the actions and stance of specific RHAs, CHEs and local communities, while at the national level they involve broader issues concerning the operation of the

health reforms. In contrast to similar communities in Otago, Darfield was very fortunate in that it was able to benefit from the support of Canterbury Health, as well as increasing public opposition to the health reforms at the national level. Consequently, the Darfield community was able to retain its hospital for an additional eighteen months until July 1997, at which time, the locality planning exercise would be complete, and the issue would be open to re-negotiation between the community, CHE and SRHA.

It was not until July 1994, with the release of the SRHA's planning document *Planning for the South,* that Darfield hospital had the first indications that it was again under threat. In response to *Planning for the South*, the Darfield community mobilised very rapidly and in August 1994 formed a sub committee of the SRHA's district health committee to co-ordinate the community's defence of the hospital. Although there is some minor variation in how this sub-committee was formed, the predominant account indicates that it was initiated by a small group of older women in conjunction with the principal nurse of the hospital who were all members of the district health committee and who had a long association with health issues in the community. One of these women was also the chairperson of the SRHA's district health committee, and during a meeting with the SRHA, was invited by John Edwards, then Chief Executive of the SRHA, to "take the lead along the path of consultation."[45] Accepting the SRHA's offer, these women called a meeting of local people who were interested and involved in health issues to discuss the community's response to *Planning For The South*. It was from this meeting that the group decided to form a

[45]Cited in the minutes of the Sub-Committee of the Selwyn-Waimakariri District Health Committee, 19 August 1994.

committee to examine the role of the hospital within the community[46] and to:

. . .see what we could do to retain the hospital, or persuade the health authorities to keep it.[47]

The initial membership of the sub-committee involved people from the local council, including the mayor, the principal nurse of the hospital and the general practitioners, a member from the Darfield branch of Federated Farmers and one from the Women's Division of Federated Farmers, a representative from the Darfield Friends of the Hospital, and Ruth Richardson, National's former Minister of Finance. As is often the case in rural areas, many members of the committee represented more than one group. The sub-committee also expanded to include representatives from the SRHA and Canterbury Health.

Critical to understanding the importance of this sub-committee is the SRHA's concept of locality planning. When *Planning for the South* was released, it discussed the concept of locality planning, and stated that the need for in patient hospital beds in individual communities would be addressed as part of the locality planning process.[48] Crucially for the community, Canterbury Health was very quick to understand the strategic possibilities of locality planning, in that the concept offered the only means through which the community could argue for the necessity of the hospital in a way that would be listened to by the SRHA. Locality planning would identify the health needs of the community and the

[46]Interview, Darfield community member, 10 May 1996.
[47]Interview, Darfield community member, 31 January 1996.
[48]Southern Regional Health Authority, *Planning For The South,* op. cit., p. 14.

range of services to best meet those needs, which would then be the basis from which a decision over the necessity of the hospital could be made.

Canterbury Health perceived the sub-committee as representing the locality planning process identified in *Planning for the South*. However, the CHE and staff at the hospital correctly thought that many of the community members saw the sub-committee as not only a way of keeping the local community informed of events, but of saving the hospital.[49] In addition, the sub-committee was also intended as a forum to facilitate communication between the SRHA and Canterbury Health. The Darfield community had a clear perception that communication between the SRHA and Canterbury Health was initially very strained, and the community saw the sub-committee as a way of bringing both parties together to bridge this gap. As one member of the sub-committee recalled:

. . . it was acknowledged that there was a gap in communication, and then as we went on [in] the sub-committee, that closed, . . . it had something to do with the personalities involved as well as, individual ways. . . . we were all new entities and there was a need for them to come together, which we could see, and we brought them together.[50]

The SRHA agreed to participate in this sub-committee because they perceived it as part of the locality planning process, which offered the SRHA an opportunity to consult with the community over the need for hospital services. Together the locality planning and the consultation allow the SRHA to understand not only exactly what health services a community needs, but also decide whether it is willing to purchase those

[49]Minutes of the Sub-Committee of the Selwyn-Waimakariri District Health Committee, 10 August 1994 and 19 August 1994.
[50]Interview, Darfield community member, 17 May 1996.

services in that community. As one SRHA spokesperson commented on the consultative process:

we were trying to . . . find a way through, [to] try and understand what their needs are as a community and then try and fit the resources that we had available on an equitable basis to meet those needs.[51]

The SRHA also clearly rejected any notion that consultation involved producing policy documents and holding a fixed view as to their implementation. As an SRHA spokesperson also pointed out,

. . . [consultation] is . . . about hearing people's views and going in with the proposition that it is possible to change. It would have been an absolute farce if we'd gone into places like Ashburton and Darfield with a completely fixed view in our minds, and so consultation in our mind was you go with a proposition but not with a made up mind.[52]

The first meeting of the sub-committee was held in August 1994. However, that first meeting highlighted the committee's lack of legal status. As a result, it was decided at this initial meeting to make the committee a sub-committee of the RHA's district health committee. Having legal status was important because it conferred legitimacy on the committee, and hence it would be recognised by both the SRHA and Canterbury Health.

The sub-committee then proceeded to facilitate discussions between the SRHA, the CHE and the Darfield community. As with communities in Otago, initial progress was slow, for as one staff member at the hospital recalled:

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[51]Interview, Southern Regional Health Authority staff member, 11 December 1996.
[52]Interview, Southern Regional Health Authority staff member, 11 December 1996.

. . . the RHA reluctantly came forward, and reluctantly I felt, took part in the process and sent different people . . . every meeting we had a new face to deal with, and really put themselves on a go-slow.[53]

The former principal nurse of the hospital also commented about inaccuracies in data between the SRHA and herself:

. . . the RHA came armed with statistics about our hospital which were different from mine, and in fact skewed, if that's the right word, the whole picture of the activity that happened at the hospital, and that was really frustrating because it appeared, well the RHA considered that our hospital didn't do any acute care work, that we basically ran . . . a convalescent service, and that our maternity usage was much less than it actually was.[54]

Eventually the discussions with the SRHA, Canterbury Health and the Darfield community reached a point where the SRHA and Canterbury Health were a willing purchaser and a willing provider, and so both parties entered into a negotiation process over the price to be paid for the hospital services. Once the issue reached this stage, however, it became a contracting issue between the SRHA and the CHE and the community was excluded from the process.

Under the direction given to them via the Health and Disability Services Act, however, Canterbury Health possessed a very clear sense that its role was a provider health services, and as such, had to take a business approach, where it could only provide the services if it received sufficient

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[53]Interview, Former staff member Darfield Hospital, 26 April 1996.

[54]Interview, Former staff member Darfield Hospital, 26 April 1996. For a broader review of the RHAs contracting performance, see New Zealand Ministry of Health, *Review of 1994/95 RHA Contracting*, Government Printer, Wellington, 1995, and Rivers Buchan Associates, *RHAs Don't Fund, They Purchase Services: Review of 1994/5 Voluntary Sector Contracting with RHAs to Provide Health Services*, A Report Commissioned by the Ministry of Health from the New Zealand Federation of Voluntary Welfare Organisations, March 1995.

payment from the SRHA.[55] At the same time, Canterbury Health was also coming under pressure from the government to be financially accountable, and to exit from businesses that they could not in the long term operate profitably. As a Canterbury Health official comments:

. . . basically what [the government] were saying to us is, you don't have any social obligation in this, RHAs carry all that responsibility. You've got to be efficient as possible, and then given that you're as efficient as possible, at the end of the day, if you can't balance the books, then you shouldn't be in business. Stand aside and either the service won't be provided, or someone else will do it, but that's an RHA decision.[56]

The motivation for this pressure can be largely attributed to a government struggling to address the severe financial difficulties of the CHEs. In their first year of operation, CHEs made substantial financial losses, and accumulated debt in excess of $1 billion.[57] In October, the inability of the CHEs to deliver on the efficiency gains initially expected of them led the government to write off $800 million of CHE debt, and inject a further $534 million over a period of three and a half years to reduce public concern over the waiting lists.[58]

Some CHEs were also grappling with defining their core business, particularly because many communities were turning to CHEs to continue providing services. Canterbury Health, for example, perceived its core business as the provision of acute services and not community or rural health services. At the same time, however, it was also aware the Darfield community wished for them to retain services at the hospital.

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[55]Interview, Canterbury Health staff member, 9 January 1996.
[56]Interview, Canterbury Health staff member, 21 May 1996.
[57]Kareen Floyd, "Health Enterprise Debt Exceeds $1 billion", *New Zealand Herald*, 16 December 1994; Frances Ross, "CHEs Record $100m Loss and $1.25b Debt", *Dominion*, 18 March 1994.
[58]Michael Rentoul, "Health Services get $534m for 'Big Hit' on Waiting Lists", *The Press*, 14 October 1994.

This led Canterbury Health to express their willingness to the RHA and the community to continue providing services at the rural hospitals if they would get sufficient revenue from the RHA. From the SRHAs point of view, however, Canterbury Health's stance sent a mixed message over its commitment to providing services at the rural hospitals.[59]

Following the discussions conducted by the sub committee, the CHE produced an options paper for Darfield hospital in October of 1994 which outlined two options for Canterbury Health to pursue: withdraw from the provision of hospital services, or reconfigure the mix of beds to attract alternative types of patients and revenue streams.[60]

In the first option, Canterbury Health identified that withdrawing from providing services at Darfield Hospital would increase the number of patients needing to be admitted to Christchurch Hospital. In essence, the closure of Darfield Hospital would remove the option for the local general practitioners to keep patients in the community, and would instead require GPs to send them to Christchurch Hospital. The CHE estimated that at least 80 per cent of those patients would require admission.[61]

In contrast, the second option necessitated a change to the type of patients admitted to Darfield Hospital. As it was, Darfield had 10 beds, with three designated for maternity patients, and seven for general medical purposes. Under Option 2, the maternity beds would be reduced

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[59]Interview, Southern Regional Health Authority staff member, 11 December 1996.
[60]Canterbury Health, Ashburton and Community Health Services, "An Options Paper: Darfield Hospital", Internal Report, 6 October 1994.
[61]Ibid, pp. 3-4.

from three to two, while the remaining beds would be divided equally to accommodate four long stay elderly and four general medical patients. Under this option, there would be a very important difference in how the three services would be funded by the RHA. For the general medical beds, the RHA was willing to pay its benchmark price per day, but it would fund the four beds regardless of whether they were actually occupied. The maternity and long stay elderly beds, however, would be funded according to the actual usage of the service. In other words, these services would earn revenue only when they were being used by a patient. This meant that for Option 2 to be feasible, the hospital would need to maintain a high occupancy of the maternity and long stay beds, or find alternative sources of income to compensate for those times when the beds were empty.

This second option, however, had more serious financial implications for Canterbury Health. First, Canterbury Health argued it needed approximately $130 a day to supply general medical beds, exceeding the RHA's benchmark price of $120.[62] The second concerned the method of payment for the maternity and long stay elderly services. The CHE contended it needed a guarantee that a certain number of bed days would be purchased because of the fixed costs associated with running the hospitals. As a Canterbury Health spokesperson pointed out:

. . . we need a guarantee of so many bed days per annum because we know our costs are basically fixed in those hospitals, and we can't get them down because you can't run it with fewer people, and the RHA was saying we'll pay you per actual bed day, at such and such a price.[63]

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[62]The SRHA's benchmark price quoted here was derived from interviews with the CHE and community representatives. The SRHA would not comment on its price for a health service.

[63]Interview, Canterbury Health staff member, 21 May 1996.

The options paper was discussed by the sub-committee, and also presented at a public meeting organised by the sub-committee in November 1994. At that meeting, the local community indicated a very strong preference for the retention of Canterbury Health as the owner of the hospital, and again rejected the option of becoming a community trust. This paper was then accepted by Canterbury Health's Board as an appropriate basis on which to make an offer to the RHA to continue to provide services at Darfield hospital. No progress was made over December, and in February 1995, the CHE produced a second options paper, which essentially reiterated the contents of the October paper. It was on the basis of this paper that Canterbury Health then went to the SRHA with an offer to continue providing services at both Darfield and Ellesmere for a set price.[64]

However, as a CHE spokesperson commented, "there was virtually no response" from the RHA, and the issue was raised in June 1995 as part of the contracting round for the 1995/1996 year.[65] During this time, to ensure that it was putting forward a fair and reasonable price, the CHE also contracted Deloitte Touche Tohmatsu to audit their costings and the business plans for each of the hospitals. Once the Canterbury Health Board was assured the CHE had achieved its most efficient price, it approached the RHA in July seeking final prices for the services. The RHA, however, continued to offer a price that the CHE argued was insufficient for it to continue providing services at the four hospitals without exposing itself to financial risk.

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[64]Interview, Canterbury Health staff member, 9 January 1996.
[65]Interview, Canterbury Health staff member, 9 January 1996.

Because of demands on the SRHA from other issues in the region, the continued disagreement meant that the SRHA placed Darfield on their list of unresolved issues. As Canterbury Health and the SRHA were unable to agree on a resolution for Ashburton, or on Canterbury Health's total contract, this slowed progress on the rural hospitals, and so the hospital continued to operate as normal. Frustrated by the lack of progress, Canterbury Health finally decided to issue notice of intention to exit from the services at all four of their rural hospitals.

The notification of intention to exit was used as a weapon by the CHE against the SRHA, and was designed to highlight the seriousness of the CHE's financial problems concerning the rural hospitals. As a Canterbury Health spokesperson commented:

. . . it was used to indicate to the RHA that we were deadly serious about the fact we weren't getting paid enough. We're so deadly serious about it we're prepared to issue notice of exit.[66]

The situation between the SRHA and the CHE, however, was such that Canterbury Health's entire contract was still not agreed upon, and this led to intervention from Wellington. Although the participants agreed that this intervention was crucial in allowing the stalemate to be overcome, they were unwilling to elaborate on what form this intervention had taken, or how it had been successful. A spokesperson from the SRHA was only willing to comment that:

. . .a good facilitator is worth their weight in gold because they can assist to broker a deal that otherwise is stalemated.[67]

[6666]Interview, Canterbury Health staff member, 21 May 1996.

[67]Interview, Southern Regional Health Authority staff member, 11 December 1996.

An interview with the Hon Jenny Shipley indicated that her role as Minister of Health was not to dictate how these disputes should be resolved, but to ensure that a proper process was conducted in which the key actors had to demonstrate they were behaving in a responsible manner and were addressing the relevant health issues:

. . . what I say to [RHAs and CHEs] is that you can not leave an impasse. I will not have services shut simply because of entrenched positions. . . When RHAs have set rules as purchasers and locality planning is being done, I expect all of the parties to engage in an effective process which both includes consultation and flushes out the arguments. . . . and the people who I put up, and the process I insisted on in each of these cases, was a proper negotiated process. I couldn't have people behaving in an arbitrary manner, they had to behave in the public interest and show that they were focusing on health issues and transitional management.[68]

The result of this intervention was an agreement whereby the SRHA would purchase services at Darfield Hospital for a further eighteen months and Canterbury Health would continue to provide the services. This agreement would give the SRHA an opportunity to complete its locality plans, and would allow the SRHA and CHE to review the services provided by the hospitals in terms of their costs, utilisation, and discharge patterns. Completion of the locality plans was crucial for central government, because as Jenny Shipley explains:

. . . [the RHAs and CHEs] have to know what they're doing. I don't expect anyone to shut something or indeed open something if they're not sure what they're using it for in health care terms.[69]

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[68]Interview, Hon Jenny Shipley, 21 February 1997.
[69]Interview, Hon Jenny Shipley, 21 February 1997.

From the CHE's point of view, this agreement was possible because it was going to receive a "sufficient price" from the SRHA.[70] From the SRHA's perspective, closing the hospital would also involve the loss of maternity and age related services, and the SRHA felt it did not have the resources to manage adequately the transition to community based services. The SRHA also felt that:

. . .when push came to shove, we probably weren't going to achieve a lot of health gain or benefit from pushing through change in those areas, and [it would be better to] concentrate on those areas where we [believed] there [was] potential for greater change and benefit.[71]

For the Darfield community, the decision meant they would be able to retain their hospital for another eighteen months, at which time the issue would be reassessed, and potentially lead to further mobilisation.

The experiences of the Darfield community show that for the SRHA, Canterbury Health's continued provision of services at its rural hospitals was equally as consequential as Healthcare Otago's decision to withdraw. The outcome at Darfield proved that the power of the RHAs was not as strong as the reformers had intended, but that the SRHA could be circumvented by the skilful activities of the CHE and the political pressure that can be generated by negative publicity over rural hospital closure. The mobilisation of the Darfield community was crucial to this pressure, because it armed the CHE with an entirely credible threat. The events surrounding Darfield also showed that the desire of the reformers to remove the spectre of 'politics' from resource decisions has been impossible to achieve, and that paradoxically, the intervention of central

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[70]Interview, Canterbury Health staff member, 21 May 1996.
[71]Interview, Southern Regional Health Authority staff member, 11 December 1996.

government was crucial to solving the disagreements between the RHA and the CHE.

Discussion

The success of the Darfield community in gaining a short term reprieve for its hospital shows that rural communities have some ability to overcome their lack of formal power in the health system, and achieve outcomes more consistent with their wishes. Their ability to do this, however, is limited to the strategic openings created for them in the system by the interactions of the RHAs, CHEs and central government as they jockey for position and power. Unexpectedly for the reformers, it has been the actions of the CHEs that have proven to be the key players in determining the opportunities that rural communities can exploit. Rather than being merely the servants of the RHAs, the CHEs have demonstrated that it is sometimes their decisions that can create the issues to which the RHA must respond, and that this can significantly enhance or weaken the position of rural communities.

In the Southern region, it was the decisions of Canterbury Health and Healthcare Otago that advantaged the Darfield community by determining the issues the SRHA would have to address. With its decision to exit from rural hospital services in selected Otago communities, Healthcare Otago placed the SRHA in the position of very rapidly having to begin its role of identifying and purchasing health services for those communities. This task was made extremely difficult as the hospital closures generated a number of serious issues which the SRHA had not foreseen, and was poorly prepared for. As a result, the SRHA was required to build a relationship with these communities

against a background of public ignorance and hostility to the health reforms, and anger at Healthcare Otago's withdrawal. As a consequence, the SRHA was required to spend an enormous amount of time working with these communities to resolve the issues generated by the CHE's exit.

The implications of the SRHA's time in Otago were twofold for communities in Canterbury. First, the willingness of Canterbury Health to continue providing services at its rural hospitals meant that the SRHA was able to defer dealing with the issues in Canterbury while it addressed the problems in Otago. Second, the SRHA's experience with the rural Otago communities made the SRHA acutely aware of the anger that can be generated in communities when a hospital closure is announced, and the need for careful management of this anger. Hence, in Darfield, the SRHA was more inclined to maintain the status quo until it could devote more time to those communities, and so try to achieve a smoother transition from hospital services should Canterbury Health withdraw. This approach would also avoid a further public controversy over another rural hospital closure.

In contrast to Otago, a crucial factor in the Darfield community's ability to retain its hospital for another eighteen months was the support given to it by Canterbury Health. In the design of the reforms, decisions over the mix of local services were to be determined by the contract negotiations of RHAs and CHEs, with communities entitled to be consulted by the RHA only over the range of services to be provided. In Darfield, the SRHA enforced the division of these two processes, and the community was excluded from that negotiation process. By being willing to continue providing services, however, Canterbury Health

entered into negotiations with the SRHA, which if it was able to reach a satisfactory agreement on prices, would mean fulfilling the community's desire for the hospital to be preserved. By this means, the community was informally given access to a negotiation process from which it would otherwise have been excluded.

Through its willingness to act as the Darfield community's advocate with the SRHA, Canterbury Health offered the community further support. In the reforms, the CHEs were created with a very clear role: to provide health and disability support services, with the RHAs assuming all other responsibility for the social issues of ensuring communities have adequate access to health services. Despite a clear objective to operate as a successful business, however, the CHEs were also created with a statutory requirement to exhibit a sense of social responsibility to the communities in which they operate. In Darfield, Canterbury Health fulfilled that obligation by acting as an advocate for the community. In this way, as a Canterbury Health spokesperson commented:

[we] ensure that the community's arguments are heard, [and that] we try our best in negotiations with the RHA to bridge the gap, in other words we wouldn't exit from a service unless we had tried everything in our powers to convince the RHA that they should purchase, or pay the appropriate amount of money for that service.[72]

Canterbury Health has supported the rural communities by holding the SRHA to the concept of locality planning. As a Canterbury Health official explains:

We, I personally believe, have been quite instrumental in holding the Regional Health Authority to that concept, because I think they've found it more

[72]Interview, Canterbury Health staff member, 21 May 1996.

difficult that they thought it would be, but we have said we don't care how difficult it is, you've got to do it . . . we have said you must go through this process of establishing a locality plan, and you must do that in a consultative manner . . .We make it absolutely clear, in front of the community group, what the process is.[73]

By acting as an advocate for the community through holding the SRHA to account over locality planning, the CHE is not only advancing the position of the communities, but it is also advantaging its own position. In this situation, the CHE has the pivotal position, because if it supports the community, then it has the potential to extract extra revenue from the SRHA for the services. However, it also has the option of exiting from the hospital services if it cannot reach an agreement with the SRHA on price, and would suffer little harm by so doing the blame would fall on the SRHA.

Acting as an advocate for the rural communities, however, gives the CHE the ability to mobilise significant political and institutional strength. When the reforms were implemented, the institutional position of the CHEs was much stronger than that of the RHAs. This was because the CHEs were created out of the public hospitals, and were largely perceived by the public as "inheritors of an area health board tradition."[74] Whereas RHAs were seen to be more remote, and their role was initially not well understood, CHEs could be more easily identified with, and as such, quickly became the focus for local interests. Moreover, RHAs had little time with which to establish themselves in their appropriate roles, with the result that CHEs "to some extent [filled] this

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[73]Interview, Canterbury Health staff member, 21 May 1996.

[74]Pauline Barnett and Ross Barnett, "Restructuring Health: Rhetoric and Reality" in Richard Le Heron and Eric Pawson (eds), *Changing Places: New Zealand in the Nineties*, Longman Paul, 1996, p.222.

vacuum."[75] Hence, as Barnett and Malcolm identify "the status of CHEs as established institutions with information systems and local networks puts them in a strong position in relation to RHAs, not in terms of contracting . . . but in terms of the 'moral high ground' of purchasing - assessing needs and relating to the community."[76]

In contrast to the CHEs, the RHAs were created with little political legitimacy and extremely few linkages into communities. The design of the reforms deliberately sought to distance RHAs from communities, so that they could make what were seen to be difficult rationing decisions. For the CHEs, however, the political strength that they can gain from having good relationships with local communities insulates them from much of the public opposition and criticism that RHAs are subject to. This is important because the RHAs and CHEs exist in a health system that has undergone rapid institutional change, and where national and regional health administrative organisations have little guarantee of survival. The tenuous position of these organisations was confirmed with the formation of the coalition government between the National and New Zealand First parties, where it was decided to abolish the RHAs but retain the CHEs, albeit with a new name and without their competitive profit focus.

The actions of the CHEs, however, were not the sole cause of the Darfield community's ability to gain a reprieve on its hospital services. Another key factor was the intense national and local politics generated by other communities in the region, particularly Ashburton, who were threatened with the loss of hospital services. This had two primary effects

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[75]Pauline Barnett and Laurence Malcolm, "Beyond Ideology: The Emerging Roles of New Zealand's Crown Health Enterprises", *International Journal of Health Services*, vol. 27, no. 1, 1997, p. 103.
[76]Ibid, p. 103.

on Darfield. The first was to generate political pressure on the SRHA and central government. The Ashburton community passionately opposed the downgrading of its hospital facilities, and this was expressed through well attended rallies and public meetings with the Minister of Health and SRHA staff. The issue very quickly became politicised, partly as a result of the hospital's location within the Minister of Health's electorate, but also because the efforts of these communities threw the issue into the national spotlight. Once the issue was picked up by the national media, it seemed to embody everything that the public despised about the health reforms, and as such threatened their fragile legitimacy.

The public's reaction to what appeared to be the widespread cutting of rural services only increased the pressure on a government already acutely conscious of the increasing failures of the health reforms. At the national level, the health reforms were being attacked from a number of different directions. The performance of the RHAs and CHEs had not produced the efficiency gains that had been expected of them in the early health reforms literature, and staff resignations from senior management positions in the CHEs were very high.[77] Conflict within the health system was rife between RHAs and CHEs, RHAs and rural communities, and between clinicians and senior management within some CHEs. Together, these factors required the government to intervene increasingly in the sector, either through providing additional funding, or through the need to resolve disputes between the key actors. Particularly for a government feeling increasingly vulnerable in the MMP electoral arena, continued conflict over rural hospitals was very threatening.

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[77]For more detail on this see, Ferguson, *The Inconvenient Realities of Health Reform*, op. cit.

The political controversy that developed in Ashburton also meant that negotiations between the SRHA and Canterbury Health over Darfield were slowed until it reached a point where intervention from central government became necessary to facilitate an agreement between them. Consequently, the politically sensitive situation in Ashburton, together with the need to resolve the total contract with Canterbury Health meant the SRHA found it politically expedient to maintain services at Ashburton and Darfield in the short term until it could devote greater resources to managing changes in those localities.

What can be seen from this is that the strategic position of a small hospital like Darfield is dependent on the attention being paid to it by the larger actors. As Darfield represents only a tiny aspect of the SRHA and Canterbury Health's overall business, when more urgent issues arise, the SRHA and CHE are able to defer the issues raised by Darfield until a later time. This not only allows the hospital to continue as normal, but also gives the community the opportunity to complete the locality planning exercise, and assess the need for in-patient hospital services. However, Darfield's small size also makes its position more precarious because it encourages the larger actors to perceive it as being unimportant, therefore, rendering the hospital more vulnerable to closure.

Conclusions

The working of the reforms in practice has shown that contrary to the intentions of the reformers, the power relationships between government, RHAs, CHEs and local communities have not been fixed,

but rather have been very fluid, with power revolving between the key actors according to the particular mix of national and local political at any one time. For rural communities, the example of Darfield shows that power under the reforms is both highly contingent and precarious. Power is almost totally dependent on the mix of political circumstances at the national and local level, and on the ability of communities to exploit those circumstances. The experience of Darfield, therefore, offers an analytic comment on the ideas underpinning the new institutional literature. The new institutional framework argues for the primacy of institutions in shaping an actor's power, but as the health reforms have shown, informal relationships and political pressures can often be just as crucial in determining an actor's ability to make decisions and have control over other actors. Hence, an actor's true degree of power is often the product of the privileges bestowed on them by their formal institutional position together with their ability to exploit informal relationships and political pressures.

Chapter Six: Conclusion

> [I]nstitutional change rarely satisfies the prior intentions of those who initiate it. Change cannot be controlled precisely. Such a perspective, however, is itself misleading, for it presumes that intention is clear, fixed, and unitary. Understanding the transformation of political institutions requires recognising that there are frequently multiple, not necessarily consistent, intentions, that intentions are often ambiguous, that intentions are part of a system of values, goals, and attitudes that embeds intention in a structure of other beliefs and aspirations, and that this structure of values and intentions is shaped, interpreted, and created during the course of the change in the institution.[1]

In 1991, the newly elected National government embarked on a program of radical institutional reform of the health sector. This reform was undertaken with an unshakeable ideological conviction that the introduction of a 'managed market' was the way to achieve a more responsive, integrated and efficient health system. The reformers had identified that provider and community 'capture' was a key reason perpetuating inefficient and inappropriate allocations of health resources and preventing the closer integration of primary and secondary care. Area Health Boards were seen as veto points that could be controlled by communities and doctors, and hence were the institutional arena through which these interests possessed a disproportionate amount of control in the system. Consequently, the reformers designed a new institutional structure where a separate purchaser and multiple, competing providers operating in a 'managed market' would determine the allocation of resources. This system would contain no veto points directly accessible to either communities or providers, and hence would enable the RHAs to rationalise and reconfigure health resources more

[1]March and Olsen, *Rediscovering Institutions*, op. cit., p. 65.

effectively. In theory, this system would also significantly reduce the need for political interference by central government in resource allocation decisions.

In practice, however, the system has only partially produced the outcomes anticipated by the reformers. Although some rural communities, as in Otago have lost local facilities, it is significant that other communities, as in Canterbury, have been able to resist attempts to close or downsize their hospitals. Accounting for these different outcomes thus presents a puzzle. In part, the answer can be found in the ability of local communities to benefit from the strategic openings in the system created by the interactions of RHAs, CHEs and central government. In the case of rural hospitals in the Southern region, it was the actions of the CHEs that turned out to have a pivotal role in creating the opportunities from which local communities could benefit. As the account of Darfield Hospital demonstrates, it was the willingness of Canterbury Health to continue providing services at the hospital and to act as an advocate for the community with the SRHA that significantly advantaged the community. Canterbury Health's stance not only prevented the community from having to form a trust to retain their hospital, but meant that if the CHE could successfully negotiate a price with the SRHA, the community's wish for the hospital to be retained would be fulfilled. In contrast, communities in Otago did not have a supportive CHE to shelter under, and were left with little option but to form a trust if they wished to retain their hospitals. In so doing, however, the communities then had to work through a complex and often painful process with the SRHA to become a service provider.

Another piece of the puzzle can be found in the ability of the Darfield community to benefit from local and national political factors. At the local level, the controversy over Ashburton Hospital was becoming increasingly bitter and protracted, and represented yet another issue on which the SRHA and Canterbury Health could not agree. Particularly as Ashburton Hospital was in the electorate of Health Minister Jenny Shipley, it was the focus of nationwide attention and was being closely watched by other rural communities to see how it would be resolved. While the situation at Ashburton diverted the SRHA and CHE's attention away from the dispute at Darfield, the hospital was able to continue operating normally. Eventually the contract dispute required intervention from central government, and this was very significant for Darfield because the government was feeling under pressure from other disputes over rural hospitals, and was anxious to ensure that further hospital closures would incur as little political fallout as possible. This meant that for the SRHA, which was conscious that the Darfield community would not give up its hospital easily, it became prudent to delay making changes until it could complete the locality planning exercise. Not only did this avoid a political controversy, but it would also provide better information on which to assess the need for the hospital.

The pieces of the puzzle that have so far been revealed also have implications for the 'new institutionalist' theories. Whereas these theories argue that an actor's power comes from their institutional positioning, the case of Darfield Hospital has shown that an actor's formal institutional position does not always constitute their true degree of power. Rather, informal relationships and political pressures intertwine with formal institutional positioning to determine an actor's ability to control decisions and other actors in the sector. That the

Darfield community could retain its local hospital stemmed not only from the ability of the community to benefit from the politics created by other actors in the system, but also from the fact that the community could generate its own strategic opportunities by threatening to create a politically difficult situation should its hospital close. By actively mobilising and clearly indicating that they would not exit quietly from the hospital, the community posed a broader political threat to the government in the electoral arena. This pushed the issue on to the national agenda, and compelled central government to become involved in the contract dispute between Canterbury Health and the SRHA, the outcome of which ultimately favoured the Darfield community.

Consequently, contrary to the intentions of the health reforms, the Darfield community along with other rural communities, became significant actors in their own right. In the lead up to the 1996 general election, the issue of rural hospital closure was a political liability for the government. The government was feeling increasingly vulnerable in the health sector, and this was exacerbated by its need to contest the general election in the new MMP environment, where its traditional party support was looking insecure. The mobilisation of the community was an incentive for the CHE to use the community as an ally against the SRHA, and this contributed towards the SRHA's decision to continue purchasing services at Darfield Hospital at least until it could complete the locality planning exercise. Hence, the community not only benefited from favourable political circumstances generated by other actors, but also contributed to the success of its cause by vigorously contesting the loss of its local hospital.

Perhaps the most significant practical and theoretical lesson that can be learnt from the health reforms and the case of Darfield Hospital is that attempts to disempower key actors in the system are unlikely to be entirely successful. This is for a number of reasons. First, no actor exists in isolation, but rather is part of a complex network of interdependent relationships, where the actions of other actors create opportunities and barriers that can affect a single actor's strategic position and power. In the case of rural hospitals, the seemingly total power of the RHAs could be constrained by informal alliances between CHEs and local communities, and by the efforts of rural communities to thrust the issue of rural hospital closure onto the national agenda where it placed even further pressure on central government and the RHAs.

However, efforts to remove formal power from actors can paradoxically result in their gaining an increased ability to influence the outcomes of policy debates. This is because when an actor feels it has nothing left to lose, it is often able to fight more vigorously, and with less consideration of its formal responsibilities than opposing actors. In this regard, the Darfield community was significantly advantaged over the SRHA. Whereas the community may have felt "up to our knees in mud," they also had nothing to lose by using every means available to fight for the retention of the hospital.[2] The SRHA's actions, however, were severely constrained by their formal position, because they had to be seen not to be abusing their power. This was evident with the introduction of the Management of Change protocols from central government which were released in response to concerns that RHAs and CHEs were not consulting properly with communities. Crucially, attempts to remove power from any group with a fundamental stake in the system will

[2]Interview, Darfield community member, 17 May 1996.

always result in that group constantly struggling to have an input into decisions. This will be even more apparent when those decisions have important consequences for that group, as in the case of rural hospitals.

Following the 1996 general election, no single political party gained a majority in the House of Representatives, and a coalition government was formed between the National and New Zealand First parties. This coalition rejected the National government's emphasis on competition and market principles, and instead returned the focus of the sector to co-operation, collaboration and improving health outcomes. The RHAs are to be abolished in 1998, with a return to a single, central funder, although the CHEs will remain. That the RHAs are to be abolished is due in part to their failure to build good relationships with the other actors in the sector. Although the RHAs new roles as purchasers were inherently difficult and contentious, they did little to help their position. At least initially, RHAs rigidly enforced the separation between the purchaser and provider which led to their adopting a confrontational rather than collaborative approach with providers, and engaged in highly legalistic contracting arrangements which delayed and frustrated negotiations with providers and communities.[3] The RHAs could be depicted by their detractors as the epitome of unnecessary bureaucracy, and their general unpopularity made them vulnerable to abolition. In contrast, CHEs were seen to have much greater political legitimacy, and have been retained in the new system as Regional Hospital and Community Services.

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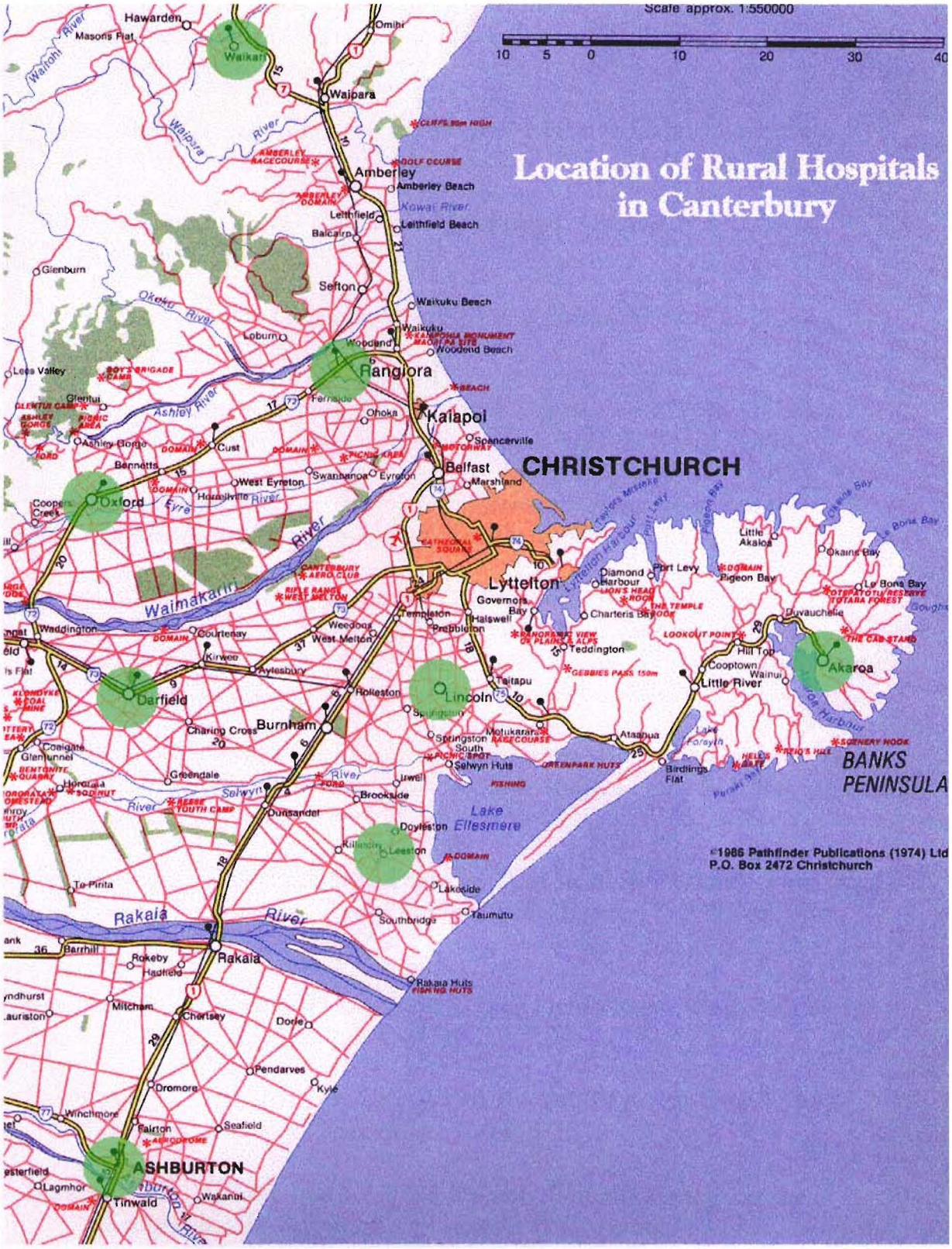
[3]For more detail see Laurence Malcolm, "Govt's New Health Policy Should Build On Successful Bits of the Old", *Christchurch Press*, 7 January 1997, p. 7; Laurence Malcolm, "What Now? Coalition Health Policy Revisited", *New Zealand Doctor*, 5 February 1997; Laurence Malcolm and Mervin Shalowitz, "Managed/Integrated Care in New Zealand: Contrasts with the USA", forthcoming in *New England Journal of Medicine*.

Although this latest round of restructuring has not eliminated the dilemmas presented by rural hospitals, the removal of competition as a driving force in the sector may allow these debates to be resolved more smoothly. For this to happen, however, the new central funder and Regional Hospital and Community Service providers will need to reincorporate rural communities back into the decision making structure. Thus, the challenge for these agencies will be to create an environment in which rural communities can work co-operatively with their local health professionals and the new health bodies to determine how their health services may best be improved. An important first step in this process will be to acknowledge that rural hospitals are more than just symbols, but are an integral part of the health services available to rural communities. Therefore, for rural communities to be able to lose the building without experiencing a bitter grieving process, they need to be able to feel secure that they will have the health services they need without feeling the community's sense of worth has been undermined.

Figure 1: Map Showing Locations of Rural Hospitals in Canterbury



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